The Vision and the Future

25 Years of CMC

CMC - Churches' Action for Health

DIFÄM Tübingen, 20-23 January 1995

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The former Christian Medical Commission of the World Council of Churches which is now called CMC - Churches' Action for Health is part of a global ecumenical movement engaged in the wide ranging issue of health and healing. This movement has many roots and a large constituency. However, one particular root goes back to the medical missions which became an important part of the global missionary movement in the last century. These medical missions were facing many questions and challenges particularly after the Second World War.

Thus, in 1962, the Division of World Mission and Evangelism of the World Council of Churches and the Commission on World Mission of the Lutheran World Federation planned a meeting to look at some of the issues facing medical missions in those days.

This meeting took place at the German Institute for Medical Mission (DIFÄM) in Tübingen in May 1964. Known as "Tübingen I", it proved to be very significant for the developing dialogue on health and healing and exerted some influence on the work of the churches in health care.

In September 1967 a second consultation on "Health: Medical - Theological Perspectives" was convened focusing on the role of the congregations in health and healing and the importance of "healing communities". It was later called "Tübingen II" and preceded the formation of the Christian Medical Commission in 1968.

Therefore CMC is now looking back at a rich and fascinating history of more than 25 years. During this time there have been remarkable changes in the understanding and organization of health care world-wide. But at the same time new challenges have evolved and there are tremendous threats to the health and well-being of people, may be as never before in the history of mankind.

For these reasons it was decided to hold a consultation to commemorate the past and to try to develop a vision which might enable us to meet the challenges of the future. The consultation was planned in such a way as to give time for some recollection of the beginnings of CMC; for a consideration of CMC's impact over that period in its various spheres of work and experience; and to current issues and future challenges for CMC, leading to some reflections towards developing a list of crucial topics for the future.

DIFÄM felt very privileged to host this meeting continuing a long tradition of consultations in our institute and a close relationship with CMC over all these years. It was our intention to invite many friends of CMC and DIFÄM who are indeed pioneers of the ecumenical movement of health and healing and of the global movement of Primary Health Care at the same time. We were overwhelmed by the response of the invitees and we are deeply grateful to all who came to Tübingen and participated in what seems to have been a stimulating and fruitful meeting.

Each participant had been invited to prepare a paper on an aspect of CMC's work and impact. However, in order to allow more time for discussion and the exchange of ideas, the presenters were asked to speak only briefly to their papers. The full texts of all the papers can now be found in this report.

The report has been divided into the main themes of the consultation: "Justice and Community", "The Impact of CMC" and "Theology of Healing". In each of these sections of the report you will first find a summary of the presentations and discussions which should enable you to get a short overview about the proceedings. For a more intensive coverage of the themes you will find the full text of the presentations following the summary. At the end

of the report there are the topics which were considered as important for the future work of CMC - Churches' Action for Health by the participants. These points were the result of intensive work in groups and of a final plenary discussion.

Attentive readers will realize that Mabelle Arole's presentation is covered in the summary but missing in the list of presentations. This is due to the fact that she kindly changed her topic during the consultation to avoid duplication with other presenters. She then gave us an extremely inspiring insight into her understanding of the involvement of the community in health. We hope that we will find these very remarkable ideas which were formulated spontaneously during the meeting in some other publication later on.

In presenting this report I would like to express my sincere gratitude to all those who have contributed to the success of the consultation and to the editing of this report. We enjoyed an excellent cooperation with all the staff members of the Unit II of WCC during the months of preparation. We are particularly indebted to Mrs. Rosemary Green who took all the minutes at the meeting and prepared the well formulated summaries which are now part of this report. I would also like to thank the staff members of DIFÄM who contributed so much time and energy for the preparations, especially Dr. Rainward Bastian for his guidance and support, Mrs. Christine Gebhardt, who has accompanied the friends of CMC for such a long time, for her skillful organization as well as Mrs. Heike Scaal and Mrs. Petra Kriegeskorte who spent many hours in writing and editing all the papers included in this report.

The intention of this report is to convey something of the atmosphere of the consultation and to recount some of the discussions and resulting conclusions that were offered to CMC: Churches' Action for Health in terms of challenges for future work in the framework of the WCC's Unit II - Churches in Mission: Health, Education, Witness. It is our hope that this report will stimulate those readers who were privileged to participate at the consultation as well as those who were not able to be in Tübingen but who are working with us in the ecumenical movement on health and healing .

Christoph Benn
Tübingen
March 1995

Opening Devotion

by Philip Potter

In the Name of God who created all things and made us in the divine image and likeness; and of Jesus Christ who is our redeemer and healer; and of the Holy Spirit who enables and sustains us in love, joy and peace; let us join in an act of praise as we sing the hymn, „Let us with a gladsome mind Praise the Lord for he is kind" (Cantate Domini 14).

Let us adore God in the prayer of a Sister:

O God, let us rise to the edges of time and
open our life to your eternity;
let us run to the edges of space and
gaze into your immensity;
let us climb through the barriers of sound
and pass into your silence;
And then, instillness and silence
let us adore you,
who are Light - Life - Love -
without beginning and without end,
the Source, the Sustainer, the Restorer,
the Purifier of all that is;
the Lover who has bound earth to heaven
by the beams of a cross;
the Healer who has renewed a dying race
by the blood of a chalice;
the God who has taken us in your glory
by the wounds of sacrifice.
God ..... God ..... God ..... Blessed be God.
Let us adore you ..... Amen.

We are meeting together today and in the coming days as a company of friends and colleagues to reflect on the Vision and the Future of our common work in the Christian Medical Commission, after 25 years of theological reflection on health and healing.

I want to meditate briefly on our theme as the Bible speaks of Vision and the Future of creation and humanity. In both the Old and New Testaments the vision of a renewed creation and humanity is sometimes expressed in terms of healing and health.

For the Old Testament we turn to Ezekiel, the great visionary among the prophets. Formost the vision of the book of Ezekiel is gloomy. It is one of judgement, and of destruction of the national life of Israel, of its land and particularly of its Temple - the place of meeting in the presence of God. When Ezekiel speaks about this fate he puts responsibility squarely on those who were called to attend to, care for and lead the people. They are the king and courtiers, the priests and prophets. He calls them the shepherds. He says in chapter 34: 1-4:

„The word of the Lord came to me: 'Son of Man, prophesy against the shepherds of Israel: prophesy and say to them - to the shepherds: Thus says the Lord God: Ah, you shepherds of Israel who have been feeding yourselves! Should not shepherds feed the sheep? You eat the fat, you clothe yourselves with the wool, you slaughter the fatlings; but you do not feed the sheep. You have not strengthened the weak, you have not

healed the sick, you have not bound up the injured, you have not brought back the strayed, you have not sought the lost, but with force and harshness you have ruled them'"

What the prophet hears and conveys to us is that the test of a healthy society which can maintain itself is whether it is a just and caring society, where none are excluded. The strong and privileged have a clear responsibility to ensure the well-being of the weak, the hungry, the sick and those who cannot cope and get lost.

Ezekiel did not stop there. He and his circle went on to paint a picture of the future in a vision of a new city, a new corporate, holistic community in chapters 40 - 48. The heart of their vision is in chapter 47 when Ezekiel sees at the centre of the city the Temple - the place of God's presence among the people and in the world. Out of the Temple is life giving spring of water flowing out through the city in all directions and especially through the desert wastes and into the Dead Sea. Life awakes all over. The dead salt sea becomes fresh water with plenty of fish. And then he says: „On the banks, on both sides of the river, there will grow all kinds of tree for food. Their leaves will not wither, nor their fruit fail, but they will bear fresh fruit every month, because the water for them flows from the sanctuary. Their fruit will be for food, and their leaves for healing." (47:12)

The word healing in Hebrew is *rapha* which means the joining, stitching together of all that is ruptured, broken, whether physical, social or spiritual. Centuries later the Greeks translated that word by the word *hygieia*, from which we get hygiene or health care. But the most interesting thing about this word is that whenever the Greek translators met the word *shalom* in the Hebrew Bible they used the word *hygieia*, healing, health, restoration of balance and wholeness, well-being in the human body and in the body politic, as well as between creation and humanity through the power of God. Indeed, Ezekiel ends his vision of the future by saying the name of the city is „Yahweh is there" (48: 35). This is precisely what the word Yahweh means - the one who is there, present and will be present with a renewed creation and a healed humanity.

All this reminds us of the famous Tübingen statement 25 years ago: „Health and healing is a dynamic state of well-being of the individual and of society, of physical, mental, spiritual, economic, political and social well-being; and being in harmony with each other, with the natural environment and with God."

The New Testament version of the future is most obvious in the book of Revelation. But the context of the vision are pastoral letters to seven young churches in Asia Minor within the repressive Roman Empire. John the Evangelist and visionary tries to arouse their awareness of the dangers they face among themselves and through persecution of the Roman Emperor Domitian. He tells them of their various illnesses, calling them to seek healing in Christ. He then proceeds to give them a vision of the future, in the spirit of Ezekiel. He writes of a new city, a new order of society and of creation which will come into being when evil is destroyed by its own weight - evil as manifested in the form of the exploiting Empire. The collapse of the oppressive political and economic forces is graphically described in chapter 18. In chapters 21 and 22 we have the final vision which John sees - the new city with its open gates so that all may mingle with each other. The responsible representatives of the nations bring into it their varied gifts which are to be shared. And in the centre of the city is the Lamb. This is a clear reference to the suffering servant brought like a lamb to be slaughtered. It is said of him: „He was wounded for our transgressions, crushed for our iniquities; upon him was the punishment that made us whole, and by his bruises we are healed." (Isaiah 53:5). At the heart of the new creation and new humanity is self-giving love which heals and makes whole.

And now John takes up Ezekiel's vision and says: „Then he showed me the river of the water of life, bright as crystal, flowing from the throne of God and of the Lamb through the middle of the street of the city. On either side of the river is the tree of life with its twelve kinds of fruit, producing its fruit each month; and the leaves of the tree are for the healing of the nations." (22:1-2).

Note immediately the difference between Ezekiel and John. Ezekiel says „the leaves of the tree are for healing" - meaning the repentant people of Israel. John says „the leaves of the tree are for the healing of the nations". No persons or peoples are excluded, unless they exclude themselves (21:8, 27; 22:3a). Healing and health are for all and with all. And what determines this wholeness, this universality is the Lamb, Jesus

Christ who came to give his life as God's servant and the servant of all, the Good Sheperd who came that we might have life in all its fulness and share that life with others.

An interesting point is the word which John uses for healing. It is *therapeia*. In classical Greek it meant mainly caring, attending to, serving others. It also came to mean curing, healing and health. There is a direct connection between physical healing and health and a constant caring relationship in service to all. Similarly, the Latin translation is *sanitas*, which is not only a matter of the body, but of the mind - a solid style of life and attitude to people and things. My school motto was: „Mens sana in corpore sano." „A sane, healthy mind in a healthy, sturdy body."

This vision of John is not intended to be a blue print for some distant, perfect society. It is rather intended to reorient the life and witness of the seven churches he was addressing, as he addresses us today. This vision and future was determined by what those churches planned to do then, how they would live out God's healing and health giving power and transmit it to others, indeed to all the nations. That is the word also for us as we meet here and in the time to come.

Summary of Personal Reflections and Current Issues

In welcoming participants, **Rev. Ana Langerak**, executive director of Unit II - Churches in Mission: Health, Education, Mission, affirmed that the experience and insight and work done by CMC in its first period of existence was helping to shape the total commitment and vision of the Unit. Ours is a vision of the promise and claim of Christ: I have come that they might have life, and life in fullness. We see this as an invitation and challenge and inspiration for our work as that part of the WCC which tries to signal the missionary vocation of the church.

Rainward Bastian (DIFÄM) expressed his pleasure that so many CMC friends had accepted the invitation to this consultation. He recalled his first experiences 25 years ago when he first came into contact with CMC friends, who had had a great influence on his own life and work.

Her Excellency **Dame Nita Barrow** gave a keynote address, describing some of her own experiences of the early days of CMC and the beginnings of Primary Health Care work. As she travelled widely, she learned so much about people and how they really live; in fact she was not aware that she was learning all the time, or even that she had captured a vision - it was not enunciated in those terms. But having learned, one is eager to share one's experiences and to make others as enthusiastic about the Christian Medical Commission in all its aspects.

Dame Nita had many a tale to relate - some amusing, some more poignant. She told of some of the highlights of the regional meetings which made such an impact on health work in many parts of the world; of the early days of cooperation with the World Health Organisation and CMC's contribution as an NGO at the UN Conference in Alma Ata on Primary Health Care.

However, although it is good to remember our beginnings and those who helped formulate the vision 25 years ago, Dame Nita urged those present to move on in the same spirit, guided by our beginnings but not handicapped by them. It is time to look at the challenges facing us in terms of the 21st century, not of the past. We began with health and healing as part of our Christian responsibility, and that can remain part of our guidance for the future.

John Bryant, the first moderator of the CMC Commission, offered some reflections on the history of CMC, recounting his own calling when Jim McGilvray invited his involvement in such terms that he could not refuse. At the top of CMC's list of tasks was the role of church-related health programmes in the development of PHC systems for populations in greatest need, and seen in the context of national development. The CMC concept was approved by the WCC Central Committee and the first meeting of the CMC Commission took place in 1968.

CMC was to play a constructive bridging role between two evolving fields of thought: how health fitted into the context of national development, and the evolving Christian view of humanity in the context of development. One of the expressions of that role was moving the health sector beyond the provision of medical and health care to empowerment, both of individuals and communities. One of CMC's contributions was to bring together the disparate programmes and interests of different church denominations enabling much closer collaboration instead of a series of separate agendas.

Although saddened by the absence of **Jim McGilvray** and **Martin Scheel**, Bryant expressed the feeling that the present gathering was a fine way to honour them and to acknowledge their contributions to the CMC, which helped to pave the way for the vision we are seeking to develop here for the future of CMC.

Hakan Hellberg noted that CMC could have taken up as its main issue the future of medical missions, but that was not the question. The question was and remains the same: How do we help those who need help? Amid all the new emphases of today on universalims, democratisation, decentralisation, we must keep hold of the idea that it is the people who count, not the institutions. On no account must this maxim be lost.

Another series of reflections from the early days of CMC was presented by **Sylvia Ross Talbot**, who entered CMC at a time when there was a growing awareness of the connection between health and justice. Discussion about the future of medical missions was going on, and novel programmes were being introduced by people like **Mabelle Arole**. Because of her experience in Guyana, she was glad when CMC moved its emphasis to community health issues, and the church's responsibility. She also had been challenged by the regional meetings, and the growing realisation that health care could not be entered into without an awareness of the role of traditional healers.

Her recollections were above all about people, the pioneers who shared some of their visions, disappointments or challenges, who took risks in order to carry on this concept, their belief that health care must involve not only medical treatment but the total person. The lively dialogue between the doctor - **Jack Bryant**, and the theologian - **David Jenkins**, was another highlight of the early years.

Women's groups in the US are actively dealing with health issues, but many churches are not involved in the health ministry at all. This was one of the things to be looked at in terms of issues that CMC should address itself to now. And if the churches are to develop a ministry of healing, they need to be enabled to do that.

Ana Langerak gave an address on current issues and future challenges for CMC. She began by mentioning some of the achievements of CMC in its 25 years of existence - theological reflection, analysis, study of international health care issues, and practical involvement in human development and health care.

In our assessment of the world situation today, and that of the church, we recognise that the overriding feature is one of fragmentation. We need therefore to strengthen the identity and selfhood of people and to continue the struggle for wholeness and community, brought together in a common commitment to Christ's promise of fullness of life.

Ms Langerak referred to some of the current issues CMC is involved in: the WCC study on HIV/AIDS; continuing focus on health issues, especially those with a justice and/or development component; cultural components of healing and wholeness in relation to the study on Gospel and Cultures, to mention a few. One of the challenges facing CMC has to do with the restoration of the 'fabric of life'. It is easy to speak of reconstructing, of reconciling, but on the basis of what? CMC through its closeness to the people who suffer and in its work with them is able to point to the essential hope: that on an inter-personal basis there is ground to create that fabric of life.

Discussion ranged over a wide area.. In relation to the location of CMC in the same Unit as mission - where it started, though it subsequently was relocated into the Unit on Justice and Service - **David Jenkins** mentioned the old question: does human life mean anything? Everyone is called in question at some stage by death, while many face poverty, disease, etc. Because of the particular globalised pressures upon us today, we have to find new ways of linking together the things that are important. He warned of the danger of attempting to be involved in everything - that will only end in destruction. If everybody tries to do everything, nobody will achieve anything. So you have to choose, but how? You need to construct a grid and locate the specificities of each Unit. He was worried if CMC got too far from medicine - it is important to stick with the very particular things.

Sylvia Talbot stressed CMC's role in consciousness raising - it had excelled in this field. **Ana Langerak** pointed to the empowering, equipping linking profile of the Unit, noting that none of that can take place without the rootedness in issues of justice/injustice, poverty, unjust distribution of wealth - the real reality. That is the strength of CMC and URM, whose voices ensure that the discussion on evangelism, on God's mission, is very concrete.

Using a diagram, **David Jenkins** explained that the Gospel has to be in the centre, together with being human. The fragmentation of the world is a threat to identity, but the gospel has to speak here, saying that there is always a point in every person being human, no matter what limits they are under; but God intends salvation. We have to remember that in anything we do about justice, service and mission, we are doing something about the gospel, trying to speak to people in a way that they are challenged. The gospel doesn't give an answer to our problems but it enables us to live with them.

Philip Potter pointed out that Jeremiah put justice, service and mission not on a different footing but as one thing - and healing is there too. It is one issue, and at the heart of it is our relationship to the grounding of our being.

Hakan Hellberg spoke of the temptation to start with "the bits" but that would have meant losing God; so we insisted on working on the totality first, then finding the bits and doing them - and therein finding God. A certain totality could be seen in the 1960s; what is the totality we are looking for in the 1990s? Again we must see that first and then find the bits and do them.

Philip Potter referred to the ecological issue which is deeply related to health and healing because of its destructive nature. We are in a situation of deep fragmentation, going back on what we thought we had learned, and it looks as if no one cares. Yet the exclusion increases and the media lulls people to go along with it. And yet, **David Jenkins** did not feel there was any call for despair over the question of totality: he saw all kinds of signs that people are dissatisfied with how things are, and they are beginning to search for the message of wholeness that contains hope. **Oliver Duku** reminded of the fact that Jesus in his healing ministry treated the individual as a totality. He stressed the need to focus on the individual as a member of a community.

Linda Senturias spoke of experience working with people living with HIV/AIDS; just when you think you are ministering to them, you find them ministering to you. We have to see AIDS in terms of people. **Ana Langerak** stressed the need to understand that we are speaking of identity and fragmentationas specific entry points; they are points were God's mission can be revealed to the people and concentrating on that, we can discover what it means to be God's people, learn what it means to share, to be active in the cause of justice. It is in the specificity that the wholeness is possible.

Philip Potter explained that the word "justice" in the OT has three things linked together - right relations with God, with one another, and with creation, inextricably bound together. "Seek first the Kingdom of God and God's justice.." - the inter-relation between God, ourselves, our community and with creation. That is what we are learning from people dealing with ecological and economic issues - by cutting these things off we are facilitating the fragmentation and destruction.

Jack Bryant gave a detailed example from his work in Thailand. The country is bewildered by the situation caused by HIV/AIDS, and the increasing instances of babies being born with AIDS, orphans because their parents have died of AIDS, the whole social-economic impact. But society is beginning to come to terms with the situation and some efforts are being made to respond to the needs, though these have yet to reach community level. It is the very fact of their being human that is being threatened - the capacity for supporting humanity is under threat. Yet they are beginning to realise that if they can deal with the enormous problems facing them, bringing about behavioural change and providing the support systems necessary to help families who are broken - will they not be a better nation?

David Jenkins agreed that changes are in process across society; trends show that there are attempts to do something, moving in the direction of being human in one world. So how should Christians respond to this? We should not ask what the Christian healing ministry is, but what contribution are Christians called to make within the area in which the healing ministry operates so that we can serve the gospel? The first contribution is reinforcement: any Christian resources and understanding must not only be put into reinforcing but into serving wherever possible. Secondly comes working for the possibility of revelation, and thirdly is being ready to offer to keep hope alive when hope is dying - "signs of hope". Bring together reinforcement, revelation, and hope against hope - and express this in the way people actually live.

Daleep Mukarji spoke of the reality of brokenness, loss of identity and all that de-humanises us in a sick society where relationships are broken in every context, and at another level, the beginning of that totality of mission and gospel. A wide understanding of the healing ministry reconciles and restores that brokenness to a totality. As we look for signs of hope we see destruction, yet God is working and is present in spite of all the destruction we see. The challenge for us is what we do as Christians, as local congregations, - how we proclaim life, healing, wholeness, justice and contribute to the building of a new community.

Session: Justice and Community

1. Devotion
by Birgitta Rubenson

As our prayer for the day we will use the South African Thuma Mina.

In the name of the Father, the Son and the Holy Spirit - let us pray:
You who is over us, you who is one of us, you who is also in us, let all see you - also in us, that we may prepare the way, for you,may thank you, for all which may then encounter us, and may thereby not forget the need of others.

Keep us in your love
as you want us to keep others in ours
that all in this our being is to your glory,
that we shall not doubt, for we are in your hand,
and in you is all strength and kindness.

Give us a clean heart - that we may see you
a humble heart - that we may hear you
a loving heart - that we may serve you
a believing heart - that we may see you.

Psalm 139

We spoke yesterday about the totality, about everything being part of everything and influencing everything and about God who is in and around everything.
We also spoke about the need of being specific, of finding our bit of being faithful to our calling and vision.

This calling of CMC has always brought us in contact with those in need - it grew out of such relationships and the continuous encounters have kept it alive, because it is in these encounters that we see God, it is then that we begin to understand what our calling as human beings is:
"to love each other as we are loved by God"
In this realization we can continue our individual lives and also our common search for CMC's future.

Let us pray:
God of mercy, we pray this morning for the world and for all people.
We pray for all those who suffer in Japan and elsewhere due to natural catastrophes.
We pray for all those who suffer in Rwanda and elsewhere due to war and conflict.
We pray for all who suffer in Peru and elsewhere due to disease and illness.
God be with them all. Save them, God, Lord, save them.

God of love, we pray this morning for the world and all people,
we pray for those we meet, for the sick and the needy, that we may be good companions in their lives and thereby let them meet you in us. We pray that we may be your witnesses of love and compassion.
God, be with us all.
Send us, God.

God of light, we pray this morning for the world and for all people.
We pray for our meeting that we may listen to each other and to you to see and understand our calling.
Give us imagination and courage to see new ways and possibilities to go out in witness and service.
God, show us your will. Show us, God.

2. Summary and Discussions

The Second Session, on Saturday 21 January, began with a meditation by **Birgitta Rubenson**. **Rainward Bastian** was moderator.

Jack Bryant presented his paper "Health, Ethics and the Dilemmas of Development"
He referred to the earlier Bryant-Jenkins dialogue which had played an important role in the early days of CMC and quoted some points which remain as relevant today as they were then (see special issue of Contact, June 1979).

The Alma Ata conference of the UN made a global impact but still did not address for example the question of local uniqueness. The phrase "targeting for equity" was coined, which recognised differential need in the context of community empowerment and development.

A Conference in Ixtapa/Mexico run by a WHO-linked body named CIOMS - an international organisation for medical sciences, concerned with ethics and so on, dealt among other issues with the birth of modern bioethics in the US. This happened at a time of intense moral upheaval associated with Viet Nam, political corruption, racism. Bioethics focused on patients as victims, rather than as looking for social support: they needed to be protected from science, and from the growing complexity of medicine. The distance between patients and doctors had for many become unbridgeable. Interestingly, the rest of the world was never mentioned in this dialogue on ethics.

In Europe, Professor Solveig of the University of Oslo pointed out that in contrast to the relative homogeneity of bioethics in the US, there was a great diversity of ethical perspectives in Europe. He spoke of "moral strangers", with different perspectives on moral issues: it was important to recognise this moral diversity and bring people together in dialogue, asking questions like: What could bind us together across cultural boundaries and ideological diversities? Will it be possible to create a theoretically sound framework for moral strangers?

An answer may be found in the human condition of vulnerability, which we all share. Thus, an ethics that takes vulnerability seriously must be an ethics for all, broad in scope and universal in reach. Ethics, justice and human rights converge on the search for human dignity. There must be a right to the opportunity to pursue good health. Moving beyond the ethics of patient care, it was time to give more attention to developing alternative decision criteria for the care of populations. A global agenda for bioethics (health ethics) needs to be drawn up collaboratively.

New syndromes of solution-resistant problems include antibiotic-resistant infections, resulting from the careless way in which antibiotics are used. The implications for health, medical care and community life are profound. Secondly, violence emerging in some countries as a new form of public health problem, focused often in inner-city settings (in the US) where large numbers of people are marginalised by society and lose hope of being accepted. These may turn against that society in ever more destructive ways - perhaps they have an agility in social pathology. The solution must not be found in reinforcing their rejection but in building an acceptance built on love, care and compassion. AIDS is often exacerbated among those in a society where people are marginalised, discriminated against, whose rights are violated. Every sector of society must join in addressing the problem - public education in culturally sensitive ways, reaching out to the vulnerable, bringing care and compassion to those who are afflicted, and using the problem as an opportunity to build a more humane society.

Bryant concluded by noting some suggestions for consideration by CMC as it seeks its vision for the future:

- join with "moral strangers" in search for common directions;
- consider how we can bridge our diversities by sharing our common vulnerability;
- participate in setting and pursuing a global agenda for bioethics;
- grapple with violence and AIDS as rising threats to humanity;
- persist in targeting for equity in the context of community development;
- continue the search for the meaning of the Gospel in the face of threats to humanity;

- re-read David Jenkins (1970s) for guidance on the role of CMC in relation to humanity's emerging and solution-resistant problems.

In discussion, **David Jenkins** mentioned the 18th century concept that there was nothing that man could not do, while nowadays we find we cannot go beyond a certain level. God in Jesus is the power who took vulnerability absolutely seriously - on the cross. **Jack Bryant** added that this also applied more recently: in the 1960s through to the early 1980s we thought we understood development and related issues, and thought that our capacity for doing health care would increase, but now we find complexities which we did not perceive then. Taking the question of violence, science is not able to define the totality of the problem and society does not know how to grapple with it. Different thinking, a different commitment and different time scales are required.

This raised the question of the definition of science, and the tools needed to resolve the problems we are facing today. Vulnerability is something we all share, it is a description of our human condition but not an answer: there are no universal answers on ethical questions. Even UN declarations are not sufficiently cross-cultural to offer a basis for our common understanding. So what does this mean for the formation of ethical principles today? What might be the specific contribution of CMC/WCC here, as a body composed of those coming from all cultures, nations, confessions, etc?

Jack Bryant agreed there was a growing understanding that there are no universal answers: the answer must be sought at country level, societal level; the problems have to be defined in terms of the local uniqueness. The answer must come not from outside but from the rising capability of local communities to deal with them. CMC's contribution could be an understanding of this fact, and of the diversity of communities, examples of uniqueness that need to be responded to. How to move from the previous global view to a more local response?

Margaret Marquart made the point that the North had made the third world believe that it had solutions, but the hope it offered had now turned into apathy and despair. So the North should admit its guilt for interfering in a world which some years ago was more whole than it is now. There is a difference between the vulnerability of the rich and that of the poor.

Concluding, **Jack Bryant** underlined the point that had emerged: beware of universal solutions! But these should not be thrown out, rather they should be adapted. If appropriate for local situations, those in positions of responsibility should be helped to see the capacities of their countries; and then to work towards building capacities, absorbing what is useful and throwing away what is not. Science should not be thrown out: it has a continuing role as a marker to indicate whether or not things are being changed, whether new ways of doing things are working or not. If CMC is to look in this direction, it can not only work with countries and help others to work with the local communities, but it also has a knowledge of the patterns of many countries so it can see what works and what does not work in those countries and what might be transferred.

Sylvia Ross Talbot then gave her presentation on "Women and Health".

Living on the margin of society is not healthy; being "sick and tired" is a daily reality for millions of women around the world. Women often carry responsibility as wage earner, farmer, water carrier, mother, home-maker, care-giver; they struggle to survive in situations of poverty, violence, war, homelessness, injustice, while struggling to keep their families intact. The result is neglect of their own health.

What causes what is wrong with women's health? The systems under which women must live make them sick and tired; strategies for intervention and prevention could hardly be effective unless this fact is considered. These systems are built on the foundation of subordination of women, reflected in the high rate of illiteracy among them, the high incidence of violence against them, the kinds of jobs they can get, the poor working conditions to which they are subjected, their absence from decision-making functions of society, the inequities of health care, inappropriate laws and procedures to which they are subjected, their limited leadership roles in the public domain, and their economic and sexual exploitation.

But this reality can be changed; women's health can be improved if fundamental changes are made in the system. But radical change must occur in all sectors of society - a transformation of the system. Women cannot do this alone but they must take responsibility to see that change takes place. Attitudes must change too. Education and

skills training is essential; where there is community development and the standard of living improved, the health status improves too. Where there is poverty and ignorance, poor health thrives.

Violence is the single most important issue affecting women today - across the world. It will soon be rare to find a woman who has not suffered violence. Gandhi said "Poverty is the worst form of violence." Institutionalised violence is often very subtle - racism, militarism, sexism, classism - creating a webb of oppression. The violence of war has a traumatic effect on women's health. Most refugees and displaced persons are women and children; many are victims of rape as a weapon of war. Economic sanctions are harmful especially for women.

But there is hope for improving women's lot: there is a wave of women's activism around the world. Women are organising around issues of economic development and economic justice, environmental issues, racism and sexism, and many other concerns. They are strategising to end violence against women, and developing agencies which provide financial support. The Ecumenical Decade of the Churches in Solidarity with Women is challenging the churches too. WCC member churches pledged commitment to act in solidarity with women in four areas: participation of women in the life of the churches; global economic injustice and the debt crisis; violence against women; racism and xenophobia.

It is important to affirm what CMC has done in the past: support given to model programmes, the promotion of primary health care, and so on. Talbot saw a number of opportunities for CMC in the future:

1. encouragement and support of an ongoing dialogue around ethical issues; the church is an ideal place to do that. Members of churches are suffering because they lack support for making decisions, e.g. abortion, surrogate motherhood, organ transplants, etc.
2. to encourage dialogue that would connect theological themes and concerns we have been sharing: economic justice, violence, moral values, health care;
3. advocacy for research on medical problems affecting women, neglected in the past.

The challenge to CMC is thus to encourage and enable churches in industrialised countries to deal more with women's health issues. There has been concentration on work with developing countries, but help is needed in the industrialised countries too, through more contact and support for churches there. Through WCC there is a growing awareness of health and healing as an important part of the ministry of the church. Talbot hoped to be a part of such dialogue as it continues to take place.

Dame Nita Barrow agreed that the churches must be pushed to take up this neglected area of women's health. The WHO Commission on women's health is talking about the same issues as we are but the results do not get fed back into the community. Yet in many local communities the power of women is very great, said **David Jenkins**. There was a whole theological area to be investigated here: the doctrine of the Trinity indicates a relational understanding of God. How do women handle and contribute to relationships?

Hari John pointed out that we talk of the equality of men and women, yet we are different: each has specific attributes and there has to be a reciprocal dependency. We need to promote harmony. **Nita Barrow** emphasised the need for women to take a firm stand - then they will succeed in achieving change; but if they cannot agree on what they want, nothing will change.

At the next session, moderated by **Margareta Sköld**, ***Hari John gave her presentation on „Health, Healing and Community Development."***

Half a billion people in India live in poverty. Some good things are happening but fundamental issues are not being addressed; there is a failure to see the interconnected nature of development and the necessity of integration. When this was realised, the result was the community development approach which began in 1971, with the purpose of raising living standards and removing poverty. The focus was not on agriculture; the poor were not involved in planning or implementing and they made all the sacrifices. Community development efforts led to the creation of a new "peasant elite": most benefits were appropriated by farmers and had no impact on the condition of the poor.

Development models were based on mechanistic theories and on GNP; community development equalled a growth approach, which led to a growing disparity between the haves and have-nots. Unfortunately for India the present government is a minority one and has no clear ideological stance and no commitment except to IMF and the World Bank. It panders to the emerging middle class and consumerist mentality. Debtor countries have the right to determine their destiny. SAPs have made problems worse: the poor health of the poor will deteriorate still further. New demons begin to corrode public confidence: growing fundamentalism, communalism, with attempts to apply 19th century solutions to 20th century problems.

These are complex issues that cannot be resolved through the application of conventional policies founded upon reductionist principles. The best development process will be one which allows greatest improvement in people's quality of life, and this depends on the possibility people have to satisfy adequately their fundamental human needs which are interrelated and interactive. Urgent steps need to be taken to fashion alternatives to community development which has proved inadequate. We would therefore like to offer a model and a strategy for serious consideration.

The social transformation approach, or community based action for transformation (CBAT), may succeed where other approaches have failed. It helps people become aware of the forces oppressing them, and of their own potential to break those forces through participatory and joint action. It implies struggle, but there is a hope that sometime they will achieve better conditions through effective organisation of the community. CBAT has 3 principles: alternative information gathering, participatory action research and training to make people realise their self-worth, and alternative action that sees health as a product of social justice. It is a comprehensive and holistic process. NGOs may facilitate it, but people own and manage their own processes, gaining self-confidence and self-respect. This is close in spirit to what Gandhi taught; villages are coming back to their original self-sufficiency. Now there is a need to take stock, look at the organisational structures and examine whether they are adequate to meet the needs of the poor.

In conclusion: The present situation is bleak due to economic policies. The traditional definition of poverty is no longer valid: we should speak of ***poverties***. Any fundamental human need which is not satisfied reveals its own poverty. Each poverty generates its pathologies - we are dealing with collective pathologies. Traditional treatments are ineffective; the whole society is unhealthy, not only the poor; this is revealed in different forms - violence, oppression, etc. Working towards true self-reliance should be the approach of NGOs now, with the poor assuming a leading role in their own development.

Development of human skills encourages people to assume responsibility. This is not for individuals alone, since a healthy society advocates the development of all people. Interdependence must combine economic growth, social justice and a harmonious way of life so that both community and individual satisfaction can be fulfilled and solidarity can prevail among equal partners. CBAT tries to change the way people perceive their own potential; development is about people - not about objects. Grassroots democratisation will bring about a growing confidence and spur to action. So it is important to build solidarity between NGOs and networks, and between them and people's movements. There cannot be a healing process where disparities exist, where people are not equal. We live in a period of transition. The challenge to us is to promote the values of an alternative society: if we don't take this up we will stand indicted by history as accomplices in creating and maintaining sick societies.

In discussion, the need to respect the wisdom of the people was stressed. The fact that people are not educated in academic terms does not mean they are stupid in matters relating to their own lives and work. Educating people outside their own communities can lead to an alienated elite returning to tell the people what to do. How can education for community remain within the community?

Governments came to accept the idea of "Health for All", but by nature a government cannot promote health by the people; it delivers services which led to a PHC approach. We cannot have either global solutions or national solutions. The churches and NGOs must facilitate measures promoting health for all.
Reference has been made to a trans-disciplinary approach, to accumulation of pathologies - there are new connections going on between grassroots villages connecting with the urban poor. The need to survive brings people together.

The next presentation was by ***Dr Oliver Duku who spoke on the theme „Primary Health Care: The Vision of the Churches on Health Care"***

We have to learn from the mistakes made in PHC, which has been described as "the poor man's medicine". One of the important elements is that it is community based; success achieved is due to the active involvement of the communities in planning and implementation of health programmes. The importance of the church as a healing community and its role in implementation of PHC is demonstrated by some church related PHC programmes in some parts of the world.

In Sudan, for example, planning has been from the top-down, with involvement of the government and WHO and some cooperation by local communities. A meeting of donors was held to enlist support for PHC from the NGOs; there was heavy dependence on external assistance, with an almost total lack of participation by local communities or traditional healers or local resources, and hardly any integration with other rural health related programmes. So PHC was seen as a reductionist measure and there was resistance to its implementation.

These mistakes were recognised and efforts made to correct them, but the corrective measures were short-lived because of the heavy financial involvement of agencies, plus the war which put to a stop everything. PHC became identified with the NGOs, not with the communities they served. But there are examples of church involvement even during this time of war, e.g. in AIDS control.

In other parts of Africa, the involvement of traditional healers has been very important; they know how the people live and look at health in its totality. The health of a person influences the whole family. Village health committees have been set up: it would be useful to know what their impact has been. The community should be taken more seriously than has been the case so far.

Different immunisation controls were set up, which worked until politics became involved and financial constraints led to the system's collapse. Malaria is the main cause of mortality along with TB, pneumonia, polio, tetanus; all could be eliminated with very little chemical application through a WHO and UNICEF joint support programme. Improved food production through improvement of farming methods, seed supplies, etc. provision of protein-rich foods could also be established.

The main weakness of the South Sudan system: Drug supply programmes where CMC played an important part were only marginally successful and many programmes collapsed. The civil war is devastating. Security is necessary to allow for the implementation of PHC programmes; involvement of the community cannot be assured in a war situation.

Church congregations are an important element in the life of the community; anything that can be done through them will be successful because people will be involved. The majority are women, who have an essential role in the health of the family and community. CMC must support the local churches and help them to be more actively involved in promoting health care in the community.

Daleep Mukarji warned against equating PHC with the healing ministry - which is the task of the church. PHC became another area dependent on outside funds. He felt it was necessary to be clear about the type of PHC we are talking about, and what the scale of CMC's involvement in PHC is.

If we understand PHC as community based, said **Oliver Duku**, are we prepared to take the time to let the community make decisions? Are the donors prepared to sacrifice their own interests, not necessarily insisting that a particular programme be identified by its name, as was the case in the past? **Birgitta Rubenson** pointed out that communities in areas which lack security often solve their problems better than those which are secure; the situation forces them to take action.

It is not always possible to use funds in ways designated by the donors, so it is the donors who have to be educated - and this can be done as long as you use clear arguments to explain what the funds are needed for, declared **Hari John**. It is again a question of knowledge and power; governments feel threatened by direct contacts between donor agencies and local communities. But it is the people who have the knowledge, and we must believe in the people.

Health, Ethics and the Dilemmas of Developement

by John H. Bryant

I. Introduction

ISSUES FROM THE BRYANT-JENKINS DIALOGUE

The situation of facing unexperienced questions is the normal condition of the people of God. We are a wayfaring people.

Technology has to do with solving problems. Theology has to do with living with problems. For communities, it is living with problems while shaping their own destiny. It amounts to practicing transcendency in the midst.

God points us toward something vital in the lives of people. What is this something?

Regarding Health for all - only God can respond FOR all - our responsibility is TO all.

What if the questions are not answerable? Many of the questions may not be answerable, but we must raise them.

Who are the poor? Those who are not cared for and to whose care no prestige is attached. This is the biblical meaning of the poor.

The CMC as part of a larger part of the organization - a representative group must be (to some extent) non-representative of the body it serves if it is to be of real service in its purposes.

Don't we need a higher capability to resolve these problems? We can serve God and humanity where we are as we are.

What is life for? What is the meaning of life?

- belonging, caring, counting, sharing, becoming...being on the way

Human rights... to what are people entitled? I doubt if the Bible has any interest in human rights whatsoever... but I think the Bible is immensely concerned about human possibility.

The motive should be love, not justice. How you count is more important than what you get.

- A framework for reflection
  - changes in the ways the world works
  - advances offset by set-backs
  - emergence of new problems
  - implications for CMC

II. Health for All

- Alma Ata... a rare transformation, global in impact; but still wanting: - complexity requires decades not years
  - global solutions do not address local uniqueness
  - many examples of effective PHC systems that are being absorbed
- Targeting for Equity ... recognizing differential need in the context of community empowerment and development
- Differential risk/need in the squatter settlements of Karachi
  - a household risk-factor index
- Rural Haiti .. a semantic problem - equity vs. egalite
- WHO's Revised Strategy for Health for All - Pursuing Equity in a Changing World

III. Ixtapa Mexico - Poverty, Vulnerability and the Value of Human Life

- The birth of bioethics in the US
  - the birth... renal dialysis and the God committees
  - three streams - therapeutic, experimental, scientific
  - a further critical factor - intense moral upheaval
  - vulnerability of patients - a starting point for US bioethics...why?
  - the growing complexity and impenetrability of the edifice of medicine
  - a bioethics that conceived of patients as victims

- Contrasts with developing countries
  - the debt-death link
  - there are the greatest medical ethical needs in terms of justice and equity
  - the need for attention to the socio-political-historical context in which ethical issues will evolve

- Contrasts with Europe
  - in contrast to the relative homogeneity of bioethics in the US great diversity of ethical perspectives in Europe
  - moral strangers meet in a dominance-free dialogue
  - what could possibly bind us together across cultural
  - boundaries and ideological diversities?
  - will it be possible to create a theoretically sound framework for moral strangers?
  - an answer may be found in the human condition of vulnerability, which we all share?

- Vulnerability as a human condition...
  - vulnerability comes in at least two forms
    - those who are inherently vulnerable, and
    - those whom society renders vulnerable
  - we need to be concerned with
    - the nature of the society and its health systems
    - how they contribute to or protect against vulnerability
  - increasingly, ethics itself can to a considerable degree be defined in terms of the moral burden associated with vulnerability
  - an ethics that takes vulnerability seriously must be an ethics for all, broad in scope and universal in reach.

- Ethics, justice and human rights converge on the search fo human dignity
  - concern for women's rights brings both ethics and human rights together

- International law is frequently referring to "health as a human right; the apparent absurdity of that statement is countered by saying that is short hand for the important point that there must be a right to the opportunity to pursue good health.

- Beyond the ethics of patient care to concern for populations
  - striking contributions have been made in the field of ethics in relation to patient care, by bringing forward morally based alternative decision criteria
  - it is time to give more attention to developing such alternative decision criteria for the care of populations

- A Global Agenda for Bioethics
  - The Declaration of Ixtapa was formulated on the notion that it is timely to bring together interested parties to develop a global agenda for bioethics (or health ethics) and to pursue the issues collaboratively.
  - CIOMS has agreed to provide a Secretariat, UNESCO will participate, as will WHO, UNICEF and other interested organizations

IV. New syndromes of solution-resistant problems?

- There may be a pattern of problems emerging that are very difficult to resolve, and some of them may be an inevitable product of our own professional and societal patterns of behaviour

- Antibiotic-resistant infections - it now appears inevitable that microbial resistance to antibiotics will emerge, particularly in light of the careless way in which antibiotics are used. The implications for health, medical care, and community life are profound. The microbes have a considerable genetic agility.

- Violence is emerging in some countries as a new form of public health problem, often focused in inner-city settings where large numbers of people are marginalized, poor, discriminated against, abandoned, living in frustration and hopelessness. Might it be said that those who are marginalized by a society and lose hope to be an accepted part of that society might well turn against that society in ever more destructive ways - an agility in social pathology? The solution must be not in reinforcing their rejection but in building an acceptance built on love, care and compassion.

- AIDS, too, is often exacerbated among those in a society who are marginalized, discriminated against, and whose rights are violated. They are not only the victims, but also the sources of spread of the epidemic to others who are ordinarily considered less marginalized. Here are circumstances in which national policy, public health technology and medical care are not enough. Every sector of society must join hands in addressing the problem - public education in culturally sensitive ways, reaching out to the vulnerable, bringing care and compassion to those who are afflicted, and using the problem as an opportunity to build a more humane society.

V. Vision for the future

- Join with moral strangers and search for common directions
- Consider how we can bridge our diversities by share our common vulnerability
- Participate in setting and pursuing a global agenda for bioethics
- Grapple with violence and AIDS as rising threats to humanity
- Persist in targeting for equity in the context of community development
- Continue the search for the meaning of the Gospel in the face of threats to humanity
- Re-read David Jenkins, circa 1970s, for guidance on the role of the CMC in relation to humanity's emerging and solution-resistant problems.

Woman and Health

by Sylvia Ross Talbot

Fannie Lou Hamer, revered African-American civil rights leader, in her struggle for racial and economic justice was often heard to say, "I am sick and tired of being sick and tired." Like most the world's women, Ms. Hamer, a poor peasant farmer from the Southern States, lived on the margin of society. But as someone said recently: "Living on the margin is not a healthy place to live!" The world's women will agree! Women have a right to experience physical, emotional, social and spiritual well-being. Ms. Hamer knew this instinctively, so she never stopped the struggle. She persevered and seized every opportunity to advance the cause of justice for women. So must the world's women.

For millions of women around the world, both in the developed and underdeveloped world, being sick and tired is the daily reality. They carry awesome responsibility as wage earner, subsistence farmer, water carrier, mother, homemaker, laborer, caregiver. They struggle to survive in situations of poverty, violence, war, homelessness, anxiety, depression, injustice, while at the same time they struggle to keep their family intact, often without family or community support. The result is neglect of their own health.

What causes the deficiencies of women's health?

The systems under which women must live - the cultural, social, economic, political and health care systems - make them sick and tired! Strategies for intervention and prevention could hardly be effective unless this fact is considered unjust and oppressive. These systems either support or are built on the foundation of subordination of women. This is reflected in the high rate of illiteracy among women, the high incidence of violence against women, the types of jobs to which they are relegated, the poor working conditions and health hazards to which they are subject on behalf of their jobs, the lack of control over the social, economic and reproductive aspects of their lives, their absence from decision-making and policy-making functions of the society, the unequity in health care and the inappropriate laws and procedures to which they are subject, their limited leadership role in the public domain, and their economic and sexual exploitation. But, this reality can be changed. Women's health can be improved if fundamental changes are made in the systems which affect their health so adversely. But change must occur in all sectors of society. The tendency to try to improve health by providing only improved health facilities and services must be challenged.

That will not work. What will work? Changes in political decisions, in cultural attitudes and practices, in social mores and social organizations, in economic policies and practices.

The type of systemic change needed must be radical, not a tinkering with the system, but a transforming of the system. Change that will restore, that will allow for equitable sharing in decision-making, that will allow access to the world's resources. Change that will ensure protection of human rights, that will promote growth and development, productivity and creativity. This would mean finding new ways of dealing with land ownership and property rights; working to eradicate discrimination of all types; reordering international political and economic relations so that the underlying principles are respect, human dignity and worth. It would mean revising development strategies and approaches to take into account their effect on women and involving women in the process. It would also mean enabling full participation in church and society. This type of radical change would require first a massive effort of consciousness - raising among both men and women.

We must admit that changing the system is a complex and formidable task. Women cannot do it alone, but they must take primary responsibility to see that it is done. It must be done by people of good will, a certain sensitivity, who can no longer be comfortable benefitting from a system which is oppressive and harmful to the body, mind and spirit of others.

Attitudes must change, too. Women's inferiority can no longer be taken for granted as natural and immutable. Attitudes, laws and practices which support subordination and thus restrict or limit the personal development of women will have to be addressed intentionally in every sector of society. These, of course, are changes which will take time.

But for some millions of women in underdeveloped regions of the world, immediate results in health improvement can be assured just by access to safe, clean domestic water supply and use of basic sanitary measures. For these women, finding clean water is a back-breaking, time-consuming chore, and when clean water cannot be found, they and their families suffer the debilitating, and often fatal, effects of water-borne diseases. Someone once said that the flush toilet is more valuable to our health than the National Institutes of Health! I wager that if every woman in the world had clean running water and proper waste disposal, that more than half of the problems of ill health would be resolved!

Another measure that will bring profound changes in the health status of women, and thus, their families, is access to basic education. The ability to read and write makes it possible to use vital information for preventing disease and injury. It makes it possible for women to be able to read labels on food and medicines and that is life-saving! Education and skills training lead to better-paying jobs and more control over their own life.

Community development also has an enormously salutary effect. Studies have shown that in communities where economic development is taking place and people improve their standard of living, their health status also improves. Where poverty and ignorance exist, poor health thrives. Changing the system is crucially important to women and their health.
A concern that must receive our urgent attention is violence against women. It is my belief that violence is the singlemost important issue affecting women today. Violence is so pervasive in our society that it affects all our lives. However, it affects the health of a woman in a profound way. Women are especially vulnerable. It will soon be rare to find a woman who has never been personally affected by violence. The statistics on violence against women are staggering and distressing.

According to Ghandi ,"poverty is the worst form of violence". Imagine 2/3 of the world's population live in poverty, and women are in the majority! Violence enters our lives in many forms. Only recently are women uncovering the burden of spousal abuse they have endured all these years. Their stories demonstrate over and over how the assumptions and attitudes of a patriarchal way of life rob the woman of her self-esteem and create a false sense of dependency that traps her in the abusive relationship. Women need to hear that they do not have to endure abuse, and they need to be supported in their efforts to make their homes safe places for themselves and their children. Children who live in homes where domestic violence exists are also affected. Studies reveal that children of battered women suffer from a wide range of physical and emotional problems, and are likely to be abused themselves. Therefore the woman endures double suffering, for herself and for her child or children.

Institutionalized violence is sometimes so subtle that women suffer the consequences without even being aware of the cause of their problems. It erupts in the form of racism, militarism, sexism and classism - "the web of oppression".

In analyzing racism in a recent book, „Race Matters“, a distinguished African-Americal scholar, Cornell West, observed: that its effect is a "pervasive spiritual impoverishment... The collapse of meaning in life - the eclipse of hope and absence of love of self and others, the breakdown of family and neighborhood bonds - leads to the social deracination and cultural denudement of urban dwellers, especially children. We, he said, have created rootless, dangling people with little link to the supportive networks - family, friends, school, - that sustain some sense of purpose in life. We have witnessed the collapse of the spiritual communities that in the past helped Americans face despair, disease and death and transmit through the generations dignity and decency, excellence and elegance." The pain of even the smallest segment of a society is the pain of the whole society. As the often quoted Zulu proverb states: "When there is a thorn in the toe, the whole body stoops to pick it out."

The militaristic culture in some countries has become monstrous. It provides jobs, it is true, but it also preys on women, affirms dominant, agressive behavior among men and consumes a country's resources that should have been used for national development.

The violence of war and other conflicts has a traumatic effect on a woman's health. It causes family dislocation, radical change in economic status, homelessness, disability and death, emotional trauma and mental anguish. Women and children make up the majority of the displaced persons and refugees and are especially vulnerable. More often than not, they find themselves outside their cultural milieu without resources and protection. They are victimized by men who use rape as a tool of war or who exploit them economically. Economic sanctions used against countries in times of conflict are especially challenging and harmful to women because it places additional burdens on her to find a way to keep her family alive without the goods and services usually available in her community.

Is there any hope to improve the health of women? We must answer a resounding yes to that query. Women around the world, women who suffer most and women who stand in solidarity with other women, are energetically and expectantly (pardon the pun) organizing and confronting issues affecting women's health. There is a wave of women's activism around the world. Increasingly, women's groups are organizing around issues of economic development and economic justice, groups are strategizing to end violence against women, others have organized around environmental issues, racism and sexism. Sex tourism, child prostitution, community development, appropriate technology and alternative medicine are among the myriad of other concerns which claim the attention and energies of women, all trying to find ways to justice and health.

The growing solidarity across national and ethnic boundaries is giving rise to the type of support critical to progress in this struggle. Another critical support, funding, comes from many church groups in the western world, but women are establishing their own organizations to meet that need.

How appropriate that we are having this discussion at the beginning of the second half of the Ecumenical Decade of Churches in Solidarity with Women! In 1987, WCC member churches pledged commitment to act in solidarity with women in four areas: participation of women in the life of the churches, global economic injustice and the debt crisis, violence against women and racism and xenophobia. This was in response to an insight from a United Nations study which reported that religion was one of the greatest obstacles to progress for women. It noted that the traditional prejudice that women are somehow inferior is frequently reinforced and legitimized by religious teaching. Because religion plays such a powerful role in our lives it influences how women are treated, trusted and valued. The Decade is a valiant effort to nudge churches beyond their present boundaries of concern and action to respond with faithfulness to the Gospel in these vital areas.

Reports of team visits made to most of the churches within the last two years show little enthusiasm for Decade activities among the male church leadership. However, women have been actively considering these issues, but the Decade is not for solidarity of women with women, but rather of churches with women. There is still time to challenge churches to give time and energy to study and to act on these life and death issues for women. The Christian message is a call to stand with, be present with those who struggle, those who are voiceless in the society. It is a call to act together on behalf of the whole creation which groans in travail.

The CMC-Churches' Action for Health has understood health as a justice issue and has worked untiringly to get that message across. Its publication, CONTACT, has been an excellent source of information and encouragement to people working in the field. Among other things, its role in focusing international attention on primary health care, its promotion of primary health care in every corner of the world, its emphasis on pharmaceuticals, its promotion and cultivation of coordinating councils and its outreach to engage people in the dialogue on health, healing and wholeness have had enormous influence in health improvement among women and must be affirmed.

Much more is left to be done, however, and the CMC Churches' Action for Health is in an excellent position of influence. What are the opportunities open to CMC?

- encouragement and support of an on-going dialogue on ethical issues such as abortion, surrogate motherhood, health care allocations and financing, organ transplants and others.

- encouragement of a discussion to connect theological themes and concerns such as violence, economic justice, religion and health, faith and politics, moral values and health care, to name a few.

- advocacy for research on medical problems or issues affecting women since that has been grossly neglected in the past.

- challenging, encouraging, enabling churches in industrialized countries to deal with women's health issues.

Through the work of the WCC, there is a growing awareness of health and healing as an important part of the ministry of the church.

I will be eternally grateful for this precious opportunity to be a small part of this work. Thanks again to the DIFÄM-WCC organizing committee for inviting me to participate in this very special event!

Towards the Third Millenium Community Developement and the Poor of India

by Hari M. John

After four decades of Community Development, the per capita income of the lowest 20% of the population in India has not increased more than one dollar. Indeed, the poor have become poorer and the gap between them and the richer classes has widened. The march of progress has bypassed nearly 80% of the population. It is estimated that by the year 2000 there will be more than three billion people living in poverty worldwide, specially in developing countries, half a billion in India alone. The Community Development (CD) approach, so beloved of the planners, produced often impressive results but the benefits accrued mainly to the better-off sections, 80% of the benefits going to the more affluent sections of the rural population. Rajiv Gandhi, not exactly known for his analytic powers, himself admitted that less than 20 paise of each rupee spent on community development actually went to the poor.

The inadequate understanding of the processes at work by the Planners is manifested in a variety of ways and has an impact on all sectors. Consider Infant Mortality Rate (IMR), an often misleading aggregate indicator, commonly used in measuring „development“:

Table-1:

Year	Rural	Urban
1971	138	82
1981	119	62
1991	109	52

or consider the following indicators:

Table-2:

	1982		1983		1984	
	Rural	Urban	Rural	Urban	Rural	Urban
Crude death rate	13.1	7.4	13.1	7.9	13.8	8.6
Neonatal mort. rate	72.9	38.8	73.6	39.3	72.2	39.7
Pos-natal mortality	40.8	26.4	40.2	26.5	41.1	26.7
Prenatal mortality	57.7	33.1	57.7	35.1	58.3	35.7
Still birth rate	9.8	5.2	9.4	8.4	11.0	7.9

The gaping disparity between the urban and the rural is evident. The bottom 20% of the households in rural areas, according to a study by the National Council of Applied Economic Research, shared 5% of the disposable income while the top 20% of the rural households owned and operated 53% of the disposable income. This disparity is well exhibited in the following Table too:

Table-3

Estimated Per Capita GNP in Selected Countries

Country	Per Capita GNP in US $. for total population (1990)	Estimated GNP in US $. for poorest 20% of population
Bangladesh	210	69
India	360	90
Nepal	180	28
Pakistan	400	138
Sri Lanka	470	139

In the final analysis, India failed to achieve a mode of life in which a ***statistically significant majority*** of its citizens have been able to fulfill their material and spiritual human needs. When a national society cannot achieve this, it produces a ***historical social crisis***. This exactly is what has happened in India today, the crisis we face is of enormous proportions and it is eating into the very soul of our society. As never before in our history, there is a real danger of the country coming apart and the major blame for this can be apportioned to the failure of community development to bring about qualitative transformations for the poor concurrently with quantitative increases. ***Development means change plus growth.*** Our country has shown growth and often impressive growth but it has failed to touch and change the lives of the majority.

A BRIEF LOOK AT DEVELOPMENTAL APPROACHES

Many of us know of the myriad developmental approaches and several of us have travelled these paths from 1951 onwards when Indians, mainly those in rural areas, were subjected to intense experimentation in the name of development. Briefly stated, it all began with the ***Charity Approach***, where there is a 'giver' and a 'receiver'. Charity is known to be paternalistic and often feudal, fulfilling one's religious and moral obligations. This was closely followed by the ***Welfare Approach*** where an element of the 'right' of the receiver comes in, (as the right that one expects as a citizen, from the government) but the power is still with the 'giver'. As is well known, the poor have to run from pillar to post to obtain and benefit from welfare measures. The ***Relief Approach*** is usually after a disaster, natural or man made, (this sexist word is used here deliberately because it is man who creates disasters) such as floods, drought or starvation. Here too the vulnerable are still supplicants, (and made to feel supplicants) and ***receive*** at the pleasure of the giver, at his own time and pace. Not for a moment do we look down upon these approaches - all of them have their own justification and serve their own, limited, time-bound objectives. Our concern is that they do not become „models" of development.

The limitations of these approaches were recognised and there came the ***Extension model*** where the organisations went to the people to provide services. The mobile clinics are an excellent example of this approach but this was a pure service-delivery approach, where all the decisions were made by outsiders and all inputs came from the outside. The role of the community, again, was limited, as „receivers". People were still treated as objects and provided for.

Several other approaches such as the ***Unipurpose Approach*** (for e.g. health schemes based on professionals and delivering only health care or dairy programs using dairy professionals and so on), the

Multi-sectoral Approach (seperate schemes for health, agriculture, education and such, each with its own separate objectives, staff, funds and such carried out by one NGO. Prime examples also are the non-cost-effective, verticalised programs of the WHO and UNICEF such as GOBI FFF, EPI and the Leprosy Control, Filaria Control, Trachoma Control programs of the Government).

All sorts of other experiments were done on the poor. While they probably did some good and achieved their limited objectives, they failed to address the larger and more fundamental issues concerning the poor. Their obvious lack of success can be attributed to the fact that the planners and the implementors failed to see the interconnected nature of development and the necessity of inter-sectoral integration. It was also recognised, albeit slowly, that unless the people themselves were involved in their developmental processes, at least to some extent, success will be hard to come by. The result was the ***Community Development Approach*** which was conceived and implemented in 1951, and was supposedly inter-sectoral with a defined role for people.

The main purpose of community development, as envisaged at the beginning, was to initiate a process of development that would raise the living standards of the ***majority***, i.e. the poor, in general. Removal of poverty, socio-economic equity, building of a modern society, making maximum possible use of science and technology and attainment of community self-reliance were also stated as being the basic objectives of the CD approach.

According to International Labour Organisation's „Profile of Rural Poverty", the hard core of rural poverty in rural Asia consists of agricultural labour, the landless and the near landless. Not that the planners were not aware of this, and rightfully and logically therefore, the emphasis and most of the resources should have been focused on them. Unfortunately they were not and hence the extent and prevalence of the present problem.

Briefly and historically stated, this approach covered 5265 blocks in 356 districts all over India. Soon several practical problems arose, chiefly due to the non-involvement of the 'target' group either at any stage of planning or in implementation. Though the planners, in their wisdom, spoke of „creating psychological best", lack of people's participation in the task of priority identification, program planning and management, emerged as a major bottleneck to successful implementation. The poor could not even be called as „receivers" or as „bene-ficiaries" since they did not receive or benefit from the majority of these efforts. Though the planners also called for „effort and sacrifice on the part of the ***entire body of citizens*** in order to bring about socio-economic progress", it was the poor who ended up making all the sacrifices, and therefore are where they are.

Several other problems arose also and some of them were:

1. Government plans were not realistic, and did not take the potentials of the 'beneficiaries' into account, meaning that they were treated as objects and targets,
2. money to households was not enough to make tangible changes,
3. the officials involved had little training and less skills and often zero commitment to the program. They were also mostly from the upper castes and hence could barely tolerate the lower castes, let alone work for their upliftment,
4. the benefits intended for the poor were cornered by the rural rich because of political connections and patronage, (as is the case even today),
5. widespread misappropriation and corruption by officials at various levels became the norm, (this ***'transmission loss'*** was to the tune of 80%),
6. methods and procedures were too bureaucratic and cumbersome for the poor, ill-educated villagers to cope with, (not for nothing are we Indians known as the inventors and nurturers of the concept of „red tape" and
7. there was little or no sustained monitoring and follow up.

Community development efforts, in the final analysis, led to the creation of a new class of peasant elites and progressive farmers. (This, in hindsight, perhaps was a deliberate attempt to build a powerbase by the ruling party, i.e. the Indian National Congress, since subsequently, this class has formed one of its strong pillars, the other being the industrial capitalists). „Most of the benefits were diverted and appropriated by

the better-off farmers with political influence...in the absence of a radical change in property relations and socio-political power structures, such measures made little impact on the conditions of the poor. There was an increase in the general prosperity of the country, but at the same time impoverishment also increased", says the well known economist Dantawala.

It should also be acknowledged that the social and economic theories that have sustained and directed the processes of so-called development, are not only incomplete but also inadequate. The disqueting frustrations which dominate our increasingly heterogenous and interdependent world are due to developmental models based on mechanistic theories and misleading aggregate indicators. This is also due to not accepting that development and human needs are irreductible components of a single equation.

The reason we have gone to such lengths to analyse the CD approach and its problems is because the NGO sector in India, by and large, is still stuck in this time warp of CD and thereby unwittingly continues to contribute to the growing disparity between the 'haves' and the 'have nots'. Community development is a 'growth' approach and ***growth without equity is a sham.***

THE ROLE OF THE NGO SECTOR

NGOs have often played a pioneering and prophetic role in rural development in the past. In fact the CD approach itself was first tried by the YMCA in southern India and became a sort of 'model' for later government initiatives. But the NGOs, and the Church with its money, reach and power too fell into the same trap of developmentalism, paying obeisance to the „growth model". Their problems have been manifold and they have prevented them in being effective facilitators of change. They not only failed to learn from the mistakes of others but enthusiastically continued to implement the CD approach. The major gods on the development scene, i.e. the government and the NGOs, have been found to have feet of clay.

WHAT OF THE FUTURE?

It is accepted that any government in power needs to fulfil certain conditions to have the political capacity to reform the social order from above. Among these are:

1. A coherent and stable national political leadership that has the ability to make unambiguously clear objectives, then prioritise them keeping in mind the needs of the majority and then exert sustained pressure from above for achieving those objectives.
2. A clear ***pro-lower-class ideology*** that gives the government legitimate authority to pursue goals beneficial to the rural poor. (The failure to translate „socialist" ideological commitments into a strong left-of-center regime capable of ***redistributive intervention*** is India's greatest political failure.
3. A clear and unambiguous statement on its redistributive intent. Predictability is essential for the functioning of a capitalist economy, which India's is. Strident but empty and non-practicable socialistic rhetoric does not gain much for the country.
4. An organisational ability to go to the people and penetrate the countryside without being captured by propertied groups. (The leftist regime in West Bengal has been able to achieve just this because of a committed cadre of people and grass roots participation in decision making).

Unfortunately for India, the present national government is weak, being a minority one. Hence the political leadership is not strong enough, is riven with factions competing to capture power, has no clear ideological stance and no commitment whatsoever to the needs of the majority, except to IMF/WB and their anti-poor policies. Therefore there are no plans at present targeting the poor. In fact, the poor have deliberately been left out in the cold, the government having chosen to pander to the emerging middle class and their consumerist inclinations and aspirations thus leading us on to a culture of multiple dependencies.

The priorities of the ruling classes are also in building up the military-industrial sector. India has successfully launched its own missiles and satellites, while starvation deaths have been reported from Kalahandi in Orissa, close to the missile base. More than half the villages have no access to safe drinking water.

The new players on the scene or rather those carrying the big stick now are the Brettonwoods Twins, the IMF and the World Bank. Their growing power has further restricted the capacity and the right of the so-called Debtor countries to determine their own destiny. The Structural Adjustment Programs dictated by them are most comfortable in one of serfdom. Briefly, the elements of SAP (among others) that are adding to the misery of the poor include:

- The reduction or removal of government subsidies on food, education, transport and health thereby placing a heavy and in the final analysis, unbearable, burden on the poor. They will no longer have the „safety net" of public services, inefficient as they are.

- Devaluation of currency, thus cost of imports will go up. (Pharmaceuticals in general and even life-saving drugs have already shown a marked increase in price and are thus largely out of the reach of the poor), and exports will become expensive. (This has still, fortunately, not happened, the rupee holding its own against the US dollar).

- Removal of trade and exchange controls and liberalised trade. (Free entry of multinationals and repatriation of their enormous profits - specifically using pharmaceuticals as an example, a particular Pfizer product will cost 380% more than an exactly similar Indian product.

- Privatisation of public sector enterprises, even profit making ones - specifically the health care sector has been targeted. This will surely increase health costs and ultimately affect the poor.

Besides reflecting the power of the international banking system to undermine the sovereignty of poor countries, SAP has also worsened the three most important economic problems of today's Third World -

1. rising unemployment,
2. growing inflation and in the worst case scenarios, such as in Mexico and Brazil, stagflation and
3. international indebtedness. Consider the following and its implications:

Table 4:

Estimates of Poverty
A post-liberalisation increase in incidence

Year	Poverty Ratio (%)			No.of Poor (mln.)		
	Rural	Urban	Total	Rural	Urban	Total
1987-88	39.1	40.1	39.3	231.4	78.8	310.1
1988-89	39.2	38.4	39.0	236.2	77.7	313.9
1989-90	33.7	36.0	34.3	206.7	75.1	281.8
1990-91	35.0	37.0	35.5	218.4	79.5	297.9
1991-92	40.0	37.6	39.4	255.6	81.6	337.2
1992-93	41.7	37.7	40.6	268.9	85.8	354.7

There is absolutely no question that a substantial number of poor are going to be at sea without lifeboats as the ship of state steadily sinks. Specifically the already poor health of the poor will further deteriorate and the vicious circle of ill health - non-productivity - lack of money - less food - ill health will become still more vicious.

Coupled with this, some new demons and some old ones in new garb are beginning to corrode public confidence. Chief among these is the growing ***fundamentalism*** among all major communities with its inevitable fall-out being ***communalism***. For the first time, since Independence, there is a growing sense of disquiet and alienation among the minorities. Chauvinistic tendencies based on religion, language, race and ethnicity are rampant. These are real threats to the policy and are beginning to attain unmanageable proportions.

WHAT OF THE NGOs?

While such is the case, most NGOs are on a business-as-usual approach, doing their own thing. Also most of the NGOs, with a few honorable exceptions, are wading through a morass of ideological and spiritual negativism. They are weighed down by several millstones which prevent them from rising up and facilitating the change processes. Some of these are such as

1. elitism, a sense of superiority, a holier-than-thou attitude, looking down upon other practitioners and more importantly, looking down upon traditional knowledge and skills, thus alienating the poor. This also gives rise to
2. a top-down approach, centralised planning, management and holding on to „power", the very anti-thesis of equalisation of power that they preach at the community level,
3. kingdom building - each NGO, each NGO network and each NGO network of resource agencies building up a lot of animosity, competitiveness particularly for funds, talking ill of others, back stabbing and such unsavoury activities,
4. mainstreamisation - swimming with the current, taking the easy way out, practising growth oriented technologies,
5. several other bugbears such as actionism - doing things for the sake of doing without asking why, rhetorisation - use of the latest socio-political jargon without understanding the underpinnings of it, consumerism - use of high tech gadgets, vehicles and such.

A crisis of vision leads them to keep building roads without asking where the roads are leading to and to apply, figuratively, 19th century solutions to 20th century problems. As we step into the 21st century, how do we trust frail vehicles such as these, with their proven inefficiency and poor track record, to facilitate transformatory processes of the poor? Are there any alternative structures in sight?

People's movements are a possible alternative structure but they too, once their issue-based objectives have been achieved, either fade away or become unrecognisable caricatures of their former selves - consider, for example, the post-independence Congress Party in India or the Naga movement for self rule in N.E. India.

ALTERNATIVE DEVELOPMENT

Therefore we are, in essence, forced to consider a paradigm shift - from provision of goods and services, a growth approach, decision making on aggregate indicators, over reliance on technical experts and such towards a transdisciplinary approach, an approach that will compel us to perceive and assess the world, that is people and their processes, in a manner which differs completely from the conventional one. No longer do we analyse a specific problem but instead a web of complex issues that cannot be resolved through the application of conventional policies founded upon reductionist principles.

The best development process will be that which allows the greatest improvement in people's quality of life. Quality of life depends on the possibilities people have to adequately satisfy their fundamental human needs and these human needs are interrelated and interactive.

Things have not changed for the poor in the last four decades. In fact, they have become worse and likely to deteriorate further, given the globalisation of the Indian economy. Therefore urgent steps need to be taken to fashion alternatives to community development which has failed to deliver the goods. We would therefore like to place a model and strategy for serious consideration.

The Social Transformation Approach or Community Based Action for Transformation (CBAT) looks ***likely*** to succeed where community development has failed. Based on principles of community organisation enunciated by Saul Alinsky in 1971 and combining the philosophy and principles of sustainable and participatory development, this is an approach that perceives and assesses ***people and their processes as being central to „change"***. This can also be termed as Human Scale Development where people critically analyse their situation and become critically aware of the forces oppressing them and also become aware of their own potential in breaking those forces through participatory and joint action. It is a constant and continuous struggle but a struggle devoid of cynicism, a struggle with the hope that someday, somehow they shall overcome.

The crucial pre-requisite for such an approach is the effective organisation of the community. (When we talk of communities, we mean only communities of the poor. It is our contention that unless selective bias is shown in their favour, nothing much will change. Therefore we do not recommend what are termed as Command Area approach or the total community approach). Here the NGOs have a crucial role to play, in motivating, training and capacitating grassroot community organisors in being effective partners of the poor.

In brief, CBAT, also known as PPPA or People's Participatory Planning and Action, consists of three central thrusts -

1. alternative information gathering which is Participatory Action Research (PAR). This is a process which capacitates the community to recollect the past, rediscover their potential, regenerate, elaborate and consolidate people's knowledge, analyse the various forces at work and identify options available for change,
2. Participatory Training (PT) which is a process that seeks to equip and orient the community and community workers towards the values and norms of an alternative society, a process that is liberative in itself. It makes them realise their self worth and maximises their potential. The acquisition of knowledge, skills and awareness is accompanied by a process of confidence building through group learning, and
3. Alternative action in the field, an approach that sees health as a product of social justice and thus seeks to involve poor and marginalised communities in a process that enhances their capacities and self-reliance, empowering them to struggle for social transformation. It is an approach that is built on people's knowledge and people's participation, uses only such technologies and resources as are available to, appropriate to and manageable by the people.

CBAT has been implemented with varying degrees of success by many NGOs (including experiments in Deenabandu and later on, in ANITRA Trust on a larger scale with which we have been involved as well as by several partners of ACHAN across Asia). All successful practitioners did not arrive at this approach in a vacuum or with ease. They went through several evolving approaches, each a definitive phase in the growth of people-based approaches and each with its own validity in its time and space.

Poor and marginalised communities attain self-reliance, self-confidence and are ***capacitated*** to struggle effectively against forces of oppression through CBAT which is a pan-sectoral, comprehensive and wholistic process.

In this process, NGOs, however well meaning and committed, are mere facilitators. ***People own and manage their own processes*** and gain self confidence and self respect through community action. This is close in spirit to what Gandhi envisaged as „Gram Swaraj" or Village Republics and is designed to rebuild villages back into their traditional self sufficiency. It seeks to meet the basic needs of the poor through social, economic, educational, health and moral development within the ethics of peace, non-violence and satyagraha (truthful action).

The primary foundation of this approach is built on values - values of love, concern, humility, participation, belief in people, simplicity, oneness with nature both animate and inanimate, concern for fellow creatures and for nature and such, generally not associated with „givers". In that sense CBAT is a value-based organisation of communities.

It is not possible for NGOs in their present form, with existing structures, using existing methods and approaches to participate meaningfully in, let alone facilitate these exciting processes. A structured and sustained program of „re-visioning" NGOs and of building up organisational and human development must receive the utmost priority. They need to take stock, look at themselves and their organisational structures dispassionately and examine whether they are upto meeting the challenges of the future.

IN CONCLUSION

„Human life is like forced army service, like a life of hard manual labour, like a slave longing for cool shade; like a worker waiting for his pay", says Job. This is prophetic, at least as far as the poor of the world are concerned. Their present situation is bleak and turning bleaker with every passing moment due to the new economic policies. They are condemned to a life of poverty and hard manual labour because of the failure of so-called developmental efforts. Ultimately affected is the physical, mental, economic and social well being of the poor, and among them, selectively, women.

The traditional definition of poverty is reductionist, is restricted and is based on income levels. As Max-Neef says, we should not speak of ***poverty*** but of ***poverties***. „In fact any fundamental human need that is not adequately satisfied, reveals a poverty. Some examples are: poverty of subsistence (due to insufficient income, food, shelter etc.) of protection (due to bad health systems, violence, arms race etc.), of affection (due to authoritarianism, oppression, exploitative relations with the natural environment etc.) of understanding (due to the poor quality of education etc.), of participation (due to marginalisation and discrimination of women, low-castes, minorities, indigenous people etc.), of identity (due to imposition of alien values upon local and regional cultures, forced migration, political exile etc.). But poverties are not only poverties. Much more than that, ***each poverty generates pathologies***.

We are therefore dealing with „collective pathologies of frustration" and „collective pathologies of fear". Upto the present, with our „western" scientific knowledge and reductionist approaches, we have managed to develop solutions for individual and small group pathologies. But today we are faced with an unmanageable increase in collective pathologies for which the solutions that we have on hand have proved ineffective. The consequence is that ***global*** society, be it in the West or in the East, is „collectively unhealthy", not only for the poor.

This collective ill-health (and collective pathologies of fear, anger and frustration), exhibit themselves, as we said earlier, in many different forms such as communalism, violence, oppression, fundamentalism, tribalism, discrimination and such.

It is not as though these are new problems. They have always existed but their intensity and reach are becoming unmanageable. Our communities have traditionally been fractured. In fact, the ubiquitous and malign influence of the caste system touches and disfigures every facet of our national life and has ensured that there are no such entities as „communities" in India. There are only groups of people, suspicious of each other and often hostile to each other, living side by side. A significant percentage of the population, the Dalits and the indigenous people, are doubly oppressed and continue to be treated in the most degrading manner. In spite of pious pronouncements by the ruling structures, this scenario is unlikely to change in a hurry.

Immediate and concerted efforts at developing alternatives that would provide a „safety net" for the disadvantaged should begin now and the NGOs have a crucial role to play in this.

The NGOs again, have a significant role to play in building, from the bottom up, ***healing communities***. It is not an easy task intervening into millenia-old social structures but alternative and positive action in the field through the practice of human scale development that works towards true self-reliance should be the approach of NGOs now.

Self-reliance is where people, i.e. the poor, assume a leading role in different domains and spaces, which makes it possible to promote development with synergistic effects that satisfy fundamental human needs. „Understood as a process capable of promoting participation in decision-making, social creativity, political

self-determination, a fair distribution of wealth and tolerance for the diversity of identities, self-reliance becomes a turning point in the articulation of human beings with nature and technology, of the personal with the social, of the micro with the macro, of the autonomy of planning and of civil society with the state.

Human scale development that we are talking of encourages individuals to assume responsibility for a development alternative based on self-reliance and a set of humane values based on truth.

Resources are to be generated individually and locally, using one's own efforts and capabilities and these should be used to nurture self-reliance. A healthy society advocated the development of every person and the whole person but we are not talking of individuals alone. Self-reliance must necessarily be of a collective nature. Where solidarity prevails it becomes a process of interdependence among equal partners.

Also this development does not preclude conventional goals such as economic growth since all will have to have access to required goods and services also. But what CBAT tries to do is to change the way people perceive their own potential in this scheme of things. Their sense of self-worth has been devalued through long years of playing a secondary role as objects and denigration of their personality. On the other hand, the fundamental belief of CBAT is that ***development is about people and not about objects***.

Therefore self-sufficiency in terms described above which naturally includes grassroots democratisation will bring about a growing sense of confidence among the disadvantaged and spur them on to positive, alternative and liberative action. That is why it is important to build solidarity between NGOs and between NGO networks in the first place as well as between them and people's movements on the other. There cannot be a „healing process" where monstruous disparities exist, where people are not equal. The healing process that we talk of begins and ends with coalitions of the poor, critically aware of their potential to transform themselves and primed for joint action.

We live in a period of growing turmoil and inevitable, forced and unnatural transition. This means paradigm shifts that are not only necessary but inevitable. The challenge to all of us is to internalise an approach to development based on human needs and the values of an alternative society. A sense of responsibility for the future of humanity is crucial. If we do not take up the challenge, we will stand indicted by history as accomplices in creating and maintaining sick societies, not the least of them in developed countries.

For references please contact the author

Primary Health Care: The Vision of the Churches on Health Care

by Oliver H. Duku

1. Summary

Primary Health Care based on full community participation has been recognised as the best means of achieving good health for all the people. With the scarce resources available to the poor developing countries, especially in Africa, and the rempant injustice, corruption and violence that have ravaged many of these countries, the goal of „Health for All by the Year 2000 A.D." declared in 1978 in Alma-Ata is not likely to be achieved.

We must not give up, however, but work to find ways of breaking the vicious circle of injustice, poverty, violence, hunger, disease, and further violence. Primary Health Care has been heavily dependent on external assistance. It is necessary to find methods of involving the communities and the resources available to them more actively. The use of traditional healers-herbalists, TBAs, magico-spiritual healers, etc., and a wholistic and intersectoral approach are necessary for success in tackling the problems of malnutrition and ill health in the developing countries. External assistance is important. But this should play an enabling and capacity-building role through training and encouragement of local initiative and use of local resources.

Above all, the need for justice, peace, and political stability cannot be over-emphasized. For without justice and peace and without breaking the circle of injustice, poverty, violence, and hunger, we can never hope to achieve „health for all" anytime soon.

2. Introduction: Health Care for the Poor - Primary Health Care

„The best focus for discussion about development, justice, and solidarity with the poor can be expressed in our concern for children. Let us make a world in which we can be sure that children can survive, that they can be happy and realise their potential. If we do all of that, our other concerns for peace and justice and healing and caring will also be satisfied."

This statement was made at the Sixth General Assembly of the World Council of Churches in Vancouver, Canada, in 1983, six years after the WHO/UNICEF Alma-Ata declaration of „Health for All by the Year 2000 A.D."

With an infant mortality rate of over 150/1000 live births in over sixteen of the poorest countries in Africa, compared to 11/1000 in industrialised countries and a rapidly deteriorating food and security situation in many of these countries, the goal of „Health for All by the Year 2000 " appeared to be beyond reach. The situation was no better in many other developing countries in Asia and Latin America. A radical change in health delivery strategy, with realignment of scarce resources was needed, with an increased focus on the vulnerable groups of women, children, and the elderly.

With dwindling food supplies, increasing insecurity, greater priority given to military expenditure, and meagre financial and manpower resources available to these countries, Primary Health Care received lower priority in the overall health budgets of developing countries.

Much has been written about the Primary Health Care (P.H.C.) concept, „the poor man's medicine", about its popularity with the politicians and town dwellers in developing countries, of hospital-based, pharmaceuticals dependent health care, and the inaccessibility to and non-affordability of these health care systems to the majority of rural populations in these countries. The Poor are caught in a vicious circle of persistent injustice, poverty, and hunger, leading to violence and further injustice and poverty, violence, and human suffering. . This cycle must be broken if there is to be any hope for progress toward the goal of

health for all the people. It is certainly too late to talk of „Health for All by the Year 2000". Changes in political power structures are necessary to correct the injustices that are responsible for the violence and poverty which have resulted in hunger and disease in these countries. As correctly pointed out by Rose Sumah, „the majority of the people in the world are poor because power and resources are controlled by a few." Under the present circumstances it is impossible to achieve the goal of HFA

3. Why Primary Health Care?

Many developing countries realised, well before the Alma-Ata Conference of 1978, that their resources were inadequate to provide the basic health care needs of their populations. The pharmaceuticals dependent, hospital-based health care system could not reach the majority of the rural population (80%), many of whom were women and children. There was a danger of a drift into the urban areas from the countryside in search of services that were not availed to the rural areas: health, education, clean water, etc. A less expensive, easily accessible and affordable health care system was therefore necessary for the majority of the rural population to overcome sickness, poverty, and the high infant mortality rate.

In the Sudan, the National Health Services, in collaboration with the WHO, started planning for a community-based, multisectoral health care programme as early as 1975. It was realised that health was not exclusively a medical problem, as one Senior Ministry of Health official stated: „Health is too important to be left in the hands of the health professionals alone."

The wholistic approach to health care has long been promoted by C.M.C. since its establishment. The basic human needs of food, shelter, water, clothing, education, and employment can only be met through the multisectoral, community-based approach that Primary Health Care provides. According to Dr. Stuart Kingma, only 28% of the population of the thirty-eight poorest countries (25 of them in Africa) had access to clean water in 1983. The situaton has not changed much despite the International Decade of Clean Water Supply. Increased food availability (through agricultural extension services, improved seeds, and ox-ploughing), improved rural water supply, and better housing and sanitation, improved family income and better education coupled with childhood immunisation and control of communicable diseases would go a long way toward reduction in morbidity and infant mortality and making the goal of „health for all" a realistic undertaking. A community-based approach was, and still is, the most appropriate and cost-effective way of achieving the above goals. Women play a leading role in the economic and health life of the family in the Sudan. The traditional healers, herbalists, and traditional midwives (TBAs) are important figures in the health care delivery system in the Sudan and most other African countries. A community-based health care system was therefore the most appropriate health care systems. This was adopted in the Sudan in 1976, with assistance from WHO, UNICEF, CMC, AMREF, USAID, GTZ, NCA, and many other NGOs. Many countries have adopted a number of strategies for the implementation of the Primary Health Care concept, both in developing countries and in some urban poor areas of some industrialized countries.

In many countries in Africa the implementation of Primary Health Care is heavily dependent on external assistance (financial, material, and logistic). However, the majority of the population in the rural areas still depend on traditional healers. The involvement of these traditional healers (magico-religious, herbalist, Traditional Birth Attendants) in Primary Health Care delivery is important, especially as their system of remuneration is already acceptable to the rural community. Traditional healers are popular in addition because they approach the sick persons in a wholistic manner. They provide not only physical but psychological and spiritual healing. Some of the rural people look at illness as „a lack of harmony in the family or community which becomes manifested in the individual". A wholistic approach to health care is therefore essential.

4. The Sudan Experience

The Republic of Sudan was one of the first countries in Africa to implement the P.H.C. concept. With the help of the WHO, UNICEF and AMREF, the P.H.C. concept, discussed above, was formulated into a Rural Health Care programme in Southern Sudan in 1975. Implementation started in 1976 with manpower training, development of a training curriculum for community health workers, and upgrading and renovation of rural dispensaries and dressing stations. Similar activities were initiated in North Sudan in

1977. From the start a steering committee composed of senior staff from the Health, Agriculture, Education, Community Development, Housing, Finance, and Planning Ministries and rural water supply, was established. Community involvement through selection, supervision, and support of health workers, namely, community health workers and village midwives, was an important part of the Primary Health Care Programme. However, the tendency has been to identify the P.H.C. with the Ministry of Health only. Another weakness of the P.H.C. Programme in Southern Sudan was its overwhelming dependence on external assistance. Programmes became identified with the NGOs assisting the Government of Sudan in implementing the P.H.C. Programme in a particular area. Thus we had the GTZ/GMT Project in Western Equatoria, the NCA Project in Eastern Equatoria, the LWF Project and the SCC Projects in the Upper Nile region, etc.

Therefore community participation with the programme was weakened. The problem was further complicated when some elements of Primary Health Care, like EPI and CDD were started as vertical programmes by the Ministry of Health. Fortunately, the Ministry soon corrected the situation by integrating these programmes into the overall P.H.C. Programme in the field despite the fact that they remained vertical programmes centrally.

5. The WHO/UNICEF Joint Nutrition Support Project (JNSP)

In 1985 the WHO and UNICEF jointly initiated a new multisectoral approach to nutrition in eighteen developing countries with funding from the Government of Italy. The Sudan was one of the countries in which this new approach was to be tried out. Two areas were selected as pilot project areas, one in the North (Red Sea area) and one in the South (Eastern Equatoria). This was an opportunity to try the intersectoral approach to the Primary Health Care concept. Had it continued and had it been replicated in other areas, this approach could have improved the Primary Health Care and general health and nutrition situation in the Sudan.

The commonest causes of ill health in the Sudan are malaria, malnutrition, communicable and endemic tropical diseases, and other conditions associated with ignorance, poor sanitation, and shortage of clean water supply. The commonest diseases causing morbidity and infant mortality are malaria, gastro-enteritis and dysentery, upper and lower respiratory tract infections, and pneumonia. Tuberculosis, intestinal work infestations, Protein Energy Malnutrition (PEM), anaemia, polio, and tetanus are other common causes of infant mortality. The WHO/UNICEF Joint Nutrition Support Project was therefore designed to incorporate the Primary Health Care elements that deal with the above problems. The objectives were therefore a multisectoral approach as outlined below:

1. Improved food producton through improved farming methods - agricultural extension services with improved seed supply and promotion of ox-ploughing.
2. Provision of protein rich foods through family poultry keeping for eggs and meat; keeping of domestic animals for milk and meat, and encouragement of fishing.
3. Control of endemic and communicable diseases through improved sanitation, childhood immunization (EPI), health education, and provision of clean water supply.
4. Early and vigorous treatment of diarrhoea and dysentery with ORS, and antibiotic treatment of respiratory tract infections, including anti-tuberculosis drugs.
5. Maternal and child welfare clinics: Regular examinations of pregnant women, together with health and nutrition education, family planning (child spacing) and safe delivery at home or in the hospital, and Tetanus Toxoid Immunisation. Additional midwives had to be trained to provide adequate midwifery services in the villages. Thus Traditional Birth Attendants (TBAs) were given three weeks of training using a special curriculum developed in collaboration with the AMREF.

The Health Sector and Community Development Programmes were planned and implemented in collaboration with the AMREF/USAID Rural Health Support Project and with other NGOs working in the relevant fields. Manpower development and training was a key element for the success of the programme. Therefore JNSP and AMREF jointly assisted the Regional Ministry of Health in Southern Sudan to upgrade and develop training curricula for each of the paramedical training schools - Community Health Workers, Village Midwives, TBAs, Sanitary Technicians, and Medical Assistants Schools.

An important activity of the WHO/UNICEF JNSP was the development of an intersectoral management structure. This Management and Coordinating Committee, composed of Senior Staff from the Departments of Primary Health Care, Agricultural Extension, Community Development, Finance and Planning, Rural Water Supply, Education, Housing, Information and Social Welfare, met once every two weeks under the chairmanship of the JNSP Project Manager. It reviewed progress of implementation of the projects and material and financial requirements for the field work.

6. Constraints of the Primary Health Care Programme

The main weakness of the Southern Sudan Primary Health Care Programme was its heavy dependance on external assistance for financial, logistics, and pharmaceuticals support. Attempts to involve the local government and the local communites were only marginally successful. Efforts to initiate local community stores and drug supply programmes by CMC, through SCC and other NGOs, were also only marginally successful.

Withdrawal of NGO support led, in many cases, to the collapse of the programmes. An example of this was the sudden termination of funding in February 1988 by the Italian Government, of the WHO/UNICEF Joint Nutrition Support Project. This resulted in termination of potentially successful projects like the ox-ploughing and family poultry training projects.

The effects of the current civil war have also been devastating to the Primary Health Care and other rural development programmes in Southern Sudan. A programme that was quite successful by 1989 and that had a promising future has now completely collapsed under the weight of the ever-escalating and vicious civil war!

7. Conclusion

With the increasing debt crisis in most developing countries coupled with diminishing national resources, increasing population growth, and civil disturbance, there appears to be no end in sight to the war against poverty, hunger, and disease. Political instability resulting from injustice, intolerance, and corruption makes the situation even worse.

The success achieved in the 1980s in health care delivery to the rural populations through PHC is in danger of being nullified as a result of the combination of economic crisis, political instability, and military confrontations in many developing countries in Africa and elsewhere in the Third World.

The cycle of injustice, poverty, violence, hunger, and disease must be broken, and innovative approaches to P.H.C. must receive the priority they deserve if we are at all to be able to achieve the promised goal of „health for all" in the near future.

The participation of Non-Governmental Organisations and religious bodies is essential. Full participation of the rural populations in the planning and implementation of their own health programmes should be the main objective of any assistance that is to be availed to the P.H.C. for the rural areas. Local resources and manpower such as traditional healers, medicinal herbs, community organisations, and community leadership are essential for the success of such a rural health care system. Their utilisation must be promoted. External assistance is best used in the training of manpower and strengthening of the locally available structures and resources. For the success of the P.H.C. it is necessary to assist NGOs to avoid any actions that might promote the identification of the programme with the donor agency rather than with the community in the locality.

For references please contact the author.

Session: The Impact of CMC

1. Summary and Discussions

The Third Session, on 21 January, moderated by **Linda Senturias**, began with a presentation by **Hakan Hellberg** on *„The Churches' Involvement in Health: CMC and its impact on secular organisations"* This happened in two ways: through church-related medical work, and by influencing health policies.

1. Our ability to impact secular agencies depends on our willingness to accept the ecumenical challenge. In the early days, people in government positions contested whether we could produce an ecumenical willingness. The impact always depends on us; governments were impressed when we could show examples of joint action, e.g. Malawi. Coordination varies according to where you are. We decided the degree of the impact by our willingness to accept the ecumenical challenge.
2. Health/ideological impact/community health and decentralisation: the emphasis was outside the hospitals, which did not have the impact they hoped for. The idea of empowerment met with resistance - e.g. Guatemala.

In 1974 PHC was "invented" and became the "in" thing. Its impact varied in different situations: in places where some kind of local government was functioning PHC had some success, but where there was no infrastructure, the frustration level was high and nothing happened.

Regarding the impact on donor agencies: in the 1960s, government donors were still learning the trade: large projects meant less administration, so they were reluctant to do a lot of small projects. Also there was resistance to the "community approach". From 1954 on, there was no mention of "community" or "social" by WHO. As experience grew, there was a craving for "good" projects but these were not always easy to find! Church-related (though in many ways secular) donors needed a policy to reflect theological issues.

Response depended on the people in each place; on people accepting that they were there for others rather than only for themselves. The impact on leaders came when they realised that here were Christians who wanted to be relevant in a way that made sense to them when looking at the problems that concerned them. Jim McGilvray's first visit to WHO could be compared with a "church mouse in front of the archbishop"! There was a feeling that NGOs were but a passing phase and that local governments should take over. The CMC was defined as "Medical Commission, Christian, WCC".

However, once we were seriously involved in PHC, the attitude of the WHO people changed; there was a realisation that government authorities were so inefficient that NGOs were needed as well.

There was some NGO collaboration at the Alma Ata meeting, and follow-up was often better among NGOs than on the side of governments. The view that peace is a prerequisite for health - held by CMC, WCC, WHO - has not yet convinced the powers of the world: we have not yet had the necessary impact. In some cases we have had a positive impact, in others we have caused a negative impact, and we have had some failures. We must look at these situations and see what happened, but above all, we must not give up.

In discussion, **David Jenkins** underlined the importance of a structure as a means of enabling what we are doing, but it has to be the right kind of structure - there is no easy answer. Hakan spoke of "conversion of structures" in terms of developing a structure responsive to the particular need. **Mabelle Arole** felt that one of the stumbling blocks in influencing government is the medical profession itself and its particular infrastructure.

Birgitta Rubenson felt that we had failed to bring out the problem of greed which underlies so much ill health in the world; we should do more to expose the power of greed. But how can the church pitch itself against the great powers, or against bodies like the World Bank which promote greed? asked **Kofi Asante**. **Eva Ombaka** pointed out that greed was part of human nature: can we fight that?

Hakan Hellberg saw structures as a justice issue. It is easy to start a good project, but how do you ensure its proper continuation? Some good projects have failed because there was no continuity, thus letting down the people whose hopes and expectations had been raised - this is injustice.

Mabelle Arole then spoke on *„The Impact of CMC on Community Health"*, following on from Hakan and Hari in her reflections on health and development.

Primary Health Care is not a system but an approach, an attitude. We have to recognise that health care has always existed and we tend to think we are the only ones who are providing it. But it is there, and people are the key actors, even if we are not willing to recognise them as such. Thus, however hopeless the situation may be, life goes on, and there is a continuous assessment of how people behave, and how, within their own reality, they are making choices. And those choices are limited because of the degree of their knowledge and experience.

Instead of enhancing their capabilities by sharing scientific knowledge and skills "we are sharing knowledge which we think is good for them", and we tell them this is good for them. This is where we have failed with PHC - by not allowing people to assess their own situation. How is it possible, by really working with people, to develop a conceptual framework of their own environment working with village people who have never been to school? I find a tremendous understanding in their assessment and analysis of their situation, and with the help of the village people, we came up with this conceptual framework, - the realisation that people are the key actors, that they themselves are responsible for their own health. Once they realised this, a community organisation was formed which went ahead and attacked the political structures, which were eventually replaced by their own people from the community organisation.

When true theory and practice come together, then somewhere in the middle we have the truth; knowledge and ethics must strive towards the centre which is the gospel. The gospel is liberating. Normally poor people are locked in, they have no space. But the liberating fact of the gospel and the way we behave and share our knowledge and the gospel increases the space. Once people have space, action goes on and on.

Mabelle gave a fascinating account of an experience following the earthquake in India in 1993, when the people of the village of Jamkhed were anxious to do something about the situation. Jamkhed is a very poor area, prone to drought, but the people felt they should be involved and in solidarity with a tribal people who had been displaced from their land. So they asked themselves, what do these people need? Someone to listen to them, a shoulder to cry on, help to start again. And this is what they offered, although they knew little about health, but wanted to do something, to prevent the others losing hope. It starts in a small way but I believe it will expand.

Mabelle Arole and her husband had recently published a book about their experiences in Jamkhed, entitled:
„Jamkhed - A Comprehensive Rural Health Project"

In contrast to this story of the desire of the village people to help others even poorer than themselves, **Marita Hellberg** spoke of the sad fact that in Finland today there is a lack of hope, and little sense of a meaning to life. Yet the people have all the material things they need and more.

Asked about how CMC had influenced Mabelle in her understanding of the empowerment of community, she recalled that when they first embarked on the work in Jamkhed, the only person who really supported them was Jim McGilvray and CMC who really helped them get going. Others thought they were foolish to begin without the umbrella of a university. Over the years their thinking had changed because of the opportunity for reflection and dialogue and the association with CMC in the different regional meetings.

David Jenkins pointed to the value of sharing experiences; people do things in different ways and make their own mistakes, and others can learn from this. And if you can communicate enthusiasm about what you are doing, others can be seized by this enthusiasm - this is where a network like CMC is so important.

One very important point we have to consider, concluded Mabelle, is what do we mean by quality of life and health? We tend to think of it from a Western point of view: Are we talking about imposing a Western culture? A consumer-oriented culture? A culture which is environmentally destructive? What does this mean, knowing that two-thirds of the world's resources are being consumed by the North at the cost of the environment? This is a very important factor. Globalisation -SAPs, etc - is imposing the culture of the North on the South, along with greed.

This is a very serious issue we have to consider. So we must go back to the basics and think of quality of life and of the people in the South as they see it, rather than just thinking of health from the point of view of those in the North.

Mabel de Filippini spoke of *„The impact of CMC in Latin America"*, beginning with a historic approach to the process in Latin America.

In the 15th century, the region stretching from Mexico to Argentina was discovered by Spain and Portugal. Spanish is the common language except in Brazil which is Portuguese-speaking. Independence from Spain and Portugal was won in the early 18th century, cf American and French revolutions.Through the influence of Spain and Portugal, Latin America is a Catholic continent.

Main factors ensuring the "civilisation" of a people is the establishment of a legal system and a health system. European and North American strategies were tried out as they sought to implement national systems of education and health. The result varied in different countries. Public health in general is a matter for the state, not provided until recently. A few missionary hospitals were established by Protestant churches, while both Protestants and Catholics built schools. In the early 20th century, trade unions began to establish hospitals in countries of the South to ensure better welfare for their workers. This led to a national health system on two levels: government and trade union. The private sector has only grown in importance in the last 20 years. People have a capacity for resistance; many of their values and traditional practices survive from their Afro-American cultural roots, as was the case for the usually poor immigrants from Southern Europe.

When CMC arrived, it was well received as an ecumenical model, and the emerging changes in the conception of health - like PHC - were welcomed. The 1970s were a time of contrast: dictatorships, the methodology of "disappearing" people. Nicaragua was seen as a new hope.

CMC introduced regional meetings (1979): people were anxious to communicate what was happening in their countries. *Contact* played a very significant role, as it told us about practices in other parts of the world that contribute to seeing health as a basic human right in a continent where human rights were violated daily. It also showed us the importance of people's participation: ways to improve democracy, justice and freedom, PHC principles. *Contact* provided the experience rather than theoretical approaches, and this was very important for our people and for our health programmes.

In the 1980s the situation changed: democratic governments were elected in the South. A CMC consultation in Quito about holistic health and PHC explained how churches could provide spaces of resistance to create health as a whole. The great contribution of CMC in the 80s was as a facilitator, a service to people who needed to exchange strategies and renew their visions. People could learn new approaches and apply them to their own contexts.

CMC brought five elements which contribute to maintaining its influence in Latin America:

1. consultation with representatives from several churches, including Roman Catholics;
2. AIDS programme: materials from Geneva translated and distributed by CLAI;
3. support for small projects, training communities to confront problems;
4. opportunity for participation in various meetings;
5. reaffirming the importance of communication between church leaders and community leaders, and with people all over the world.

Nita Barrow mentioned the 1992 gathering in Rio de Janeiro where the indigenous people of Latin America and the Caribben worked together; this resulted in one of the most outstanding NGO meetings, where health was one of the issues.

In the two presentations by Mabelle Arole and Mabel de Filippini, Rainward Bastian saw the common denominator of PHC as a matter of attitude. How can CMC nourish this attitude that people matter? **Margareta Sköld** saw it also as a matter of methodology; *Contact* had tried to demonstrate models used in different areas, describing how people have gone about setting up health programmes. This approach allows people to analyse their own reality and define the problems they want to address.

Hakan Hellberg agreed that one of the secrets of CMC is the platform it has provided for sharing of experiences of people and drawing conclusions from that, rather than being based on theoretical presentations.

Concluding, Mabel de Filippini posed the question: when or where can we begin to build our ethic, our village which is also an option for life? not universal, not finished, but a movement that is always changing. Our faith, our reading of the Bible is not a finished process. She affirmed her belief that Christian faith is an option for life; so health and healing are not just a medical affair, but also in our bodies and hearts. To be in contact with each other, we communicate also through our feelings and emotions.

Christoph Benn then gave some personal reflections on *„The Impact of CMC on Health Care in Industrialised Countries"*.

The impact of CMC and its ideas here in Europe may not be quite as we would like; they have not permeated the structures in our churches and church-related health care institutions, let alone government institutions. This is remarkable, since people are searching for the Christian meaning to health and healing. If they have not come into contact with CMC, we have to ask ourselves why. Is it just a problem of communication? Were the problems of industrialised countries not really being addressed? The answer probably lies in a mixture of the two. Christoph presented six theses illustrating the limitation of the impact of CMC in Europe:

1. CMC was mainly preoccupied with the problems of health care in less affluent countries. But this should not mean neglecting the health care problems in the more industrialised countries - there are many parts of our societies which are disadvantaged: we should start here if we are to influence health and healing world-wide.
2. CMC had considerable influence on the formulation of WHO principles and strategies; but contrary to its impact on global health care, WHO's influence in European countries was limited. So WHO has not been a good transmitter for CMC ideas in industrialised countries.
3. CMC used some specific terms in its publications which have a different connotation in Europe. These may be instrumental in promoting new ideas, but have sometimes taken a different meaning:
    - ***Justice***: a key word, but probably not fully understood for example in Germany;
    - ***Community***: very important - main focus of health promotion and prevention. But in Germany this concept of community no longer exists. The main focus is the individual person, often without taking into consideration the social situation, the responsibility of the individual for his own health. A new understanding of community is needed: the same concept cannot be applied world-wide;
    - ***Wholeness***: Frequently used, expressing a desire to overcome the dualism of body and soul. One problem is that "wholeness" has been poorly defined and therefore used in different ways (cf. New Age movement). So there is a need to reconsider it with the help of theologically informed anthropology.
4. The health care institutions of the churches - at least in Germany - did not take notice of developments within CMC; they themselves run a number of health care institutions, hospitals, etc. If these institutions are discussing their future, why do they not turn for example to the WCC? Why is there not more ecumenical exchange? The ecumenical movement could make an important contribution here.
5. Universities in Europe were not really involved in the discussion about the Christian meaning of health and healing. We hope to analyse the reasons for this failure.
6. Ways of communication for transmission of CMC ideas which may not always have been adequate for the needs of European health professionals. The regional consultations were outstanding (1986 Budapest) and provided an ideal opportunity to involve people from various countries. A follow up might offer a new chance here. McGilvray's book probably had the greatest impact, and it continues to be used; it is the only comprehensive account of the insights and developments in more than 25 years of debate in the ecumenical movement. *Contact* has not had that kind of impact here. So how to promote dialogue between different concepts and philosophies? The new structure of Unit II offers a chance to broaden our ambitions and provide a platform for the exchange of ideas.

Christoph Benn conluded with a list of the tasks he saw for the future of Christian health care in industrialised countries:

1. We need to ask again "who are those most in need in our societies?"

2. Challenge of the current paradigms in health care. A "paradigm shift" may be recognisable but is far from realisable.
3. Multi-sectoral and multi-cultural cooperation in the formulation of ethical principles. Churches have a great role to play here.

He said that it was his vision for the future that this multi-sectoral and multi-cultural approach would preserve the thrust of what has gone before, and open up our churches and institutions for a new paradigm of health.

Daleep Mukarji pointed out that at the start, CMC was dominated by Europeans but they were caught up in the worry about the churches and medical institutions in developing countries being left in the hands of nationals as the missionaries withdrew. Only more recently have we recognised that Europe is also a mission field. A good deal of debate is going on in the North - theological debates on wholeness and health care - but CMC has not been in touch with it so far.

Christoph Benn agreed that missionaries dominated the early days of CMC, but that was the reason why DIFÄM kept on its agenda the need to learn from experiences elsewhere and to apply it in our own countries. So we know how difficult it is, and we cannot do it alone - that is why we need the partnership with CMC and the ecumenical movement!

Hakan Hellberg agreed that in the early days CMC did not take the North seriously. The affluent countries could afford to make mistakes, and health was improving so the pressing need was not visible. **Jaap Breetveldt** said that only a small group of ecumenically minded people in Holland were aware or involved in CMC issues; the churches do not feel they are represented by this group.

Referring to the Budapest regional meeting, **Rainward Bastian** said there were many initiatives but CMC was not closely linked to them. This richness of initiative continues but the churches often lag behind or retain their conservative attitudes. **Mabelle Arole** pointed out that CMC and WHO were known, but the medical community saw them as a threat. She felt the model was as relevant to the North as to the South: it is still a matter of "behaviour and practice". The power of medicine in the North has lulled people into thinking that technology is good. But in fact, the North probably needs wholeness more than the South!

Marita Hellberg felt that CMC could learn something from the work of Christian nursing groups in terms of what does caring mean? There is a series of "sub-disciplines" - caring science, caring theology and ethics.

It is not until you have to face limits of resources that you come up against them, said **David Jenkins**: Europe had much to learn from "third world" countries which have always had to face a scarcity of resources to deal with endless needs. Who is my neighbour? Everybody is everybody's neighbour. We shall all die, but Christ died for us: the gospel is about being saved - from real sin, real death and real despair. You can only start preaching the gospel when you realise your only hope is your own forgiveness.

The CMC and its Impact on Secular Organizations/Agencies

by Hakan Hellberg

The impact of CMC has been twofold. On the one hand the effect of the CMC emphasis on coordination of church-related medical work, including in some cases other non-governmental activities; and on the other hand the "selling" of new approaches to health and medical work, new health policies.

The coordination aspect was, and still is, a challenge to churches and church-related agencies; the ecumenical challenge. The willingness to see, accept and live the fact that health-related action binds us together even when we are used to "saying halleluja and amen in different ways". People in Government positions in developing countries very much doubted that there really was such a willingness, and unfortunately they were sometimes right. On the other hand they were duly impressed when such an openness to coordination and joint action was evident and acted upon.

The first and classical example was James McGilvray's achievements in Malawi, even before CMC was established, but as an example of what became the CMC-spirit and approach.

It is therefore not possible to estimate the impact of CMC without considering the degree of ecumenical openness, willingness and action in terms of coordinating the church-related sector. Our willingness to go "the way of the mustard seed" did determine and still determines the impact we may and can have on secular agencies. The Malawi experience did show the way for similar coordinating agencies in many different countries. The role of such coordination and its impact depends naturally on the size of the church-related sector in a given country.

On behalf of CMC I once visited Iran and Tanzania during the same week. In Iran the church-related sector was 1.5 per cent and in Tanzania 45-50 per cent of the total health sector; in rural Tanzania 60-80% depending on the region. The interest in the respective Ministries of Health was naturally proportionate.

Ideological impact

During the first period from 1968 onwards the term "primary health care" was not yet invented, we were talking about community health and decentralization (Maurice King '66 and Jack Bryant '69). The emphasis was on criticizing the attitude and practice of only remaining behind the native institutions and hospital statistics that were too good to be true and not corresponding to the visible reality of the world outside the "Christian" hospital .

But implementing the decentralized and people-related approach was not and still is not without risks. It meant empowering people and this in turn meant a threat to the "establishment". In Cameroon the efforts at decentralization were prohibited by the Government, in one instance probably because it happened within a region that mainly supported the political opposition, and if I remember correctly, in an other instance because it was within an English speaking area.

The most drastic response by secular authorities was the killing in Guatemala of twelve of some fifty trained rural health and development promoters. This was related to the basic problem of absentee landlords and their thugs, and this question is still not resolved in many Latin Americal countries. The

Jamkhed project by the Aroles had a strong impact on secular groups and a report by a WHO-colleague of marxist background gives an interesting perspective on this situation. The WHO man had heard of the Jamkhed project and was suspicious so he went to one of the communist parties in the region and enquired. After hearing enthusiastic support for the project he went to another and rival communist party (there were several in India at that time) and again got clear support for the project, and then he said: "An activity which is supported by two rival communist groups must be good!"

The strong influence of socialist and marxist ideology on many Governments in the "Third World" in the sixties and early seventies made them in principle receptive to a community oriented approach, but official health policy was still searching for its way in the sixties, and I think it is fair to say that we in CMC were in some ways spearheading the new development. - When from 1974 PHC became the watch word and gradually after Alma-Ata etc. became official policy in most places, the early church-related attempts were recognized and more readily accepted. This also helped with the "curative" resistance on the church-related side. Again a "ping-pong effect".

Impact on Donor Agencies

In the sixties most government donors were still learning the trade, had many inexperienced staff and were preoccupied with larger institutions. It has always been easier to administratively process a few large projects than e.g. many small and interrelated health centres and clinics. This meant a certain resistance to the community approach and even some accusations of socialist-marxist ideological contamination.

Mobilizing the people to take responsibility and be allowed to have a say in what concerned them was not always easily accepted during the years of the cold war. These were the years when we used to say that many large church/mission institutions were like a cemented road instead of the footpath where we should be following in the footsteps of the Lord. Some said that he had turned left off the tarred road!

As experience increased among the donors the support for "our" approach started to grow and there was a craving for "good projects", even a competition for projects that reflected the new approaches. One problem was the rapid turnover of donor agency staff. This meant taking on the task of "conversion" again and again. In the contacts with church-related donors (in many ways secular) there was a varying response to the theological knowledge and an ability to start reflecting theologically. It touched on "St. Paul's missionary methods and ours" and demanded a "primary mission service outreach" and "primary ecclesiology", an understanding of church and congregation as well as of primary health care.

With governmental and private secular agencies the response depended on what kind of people were in charge. If they were ready to be there "for others", it was easier to discuss with them than with many directly church-employed or church-related, if they again were stuck with inherited ideology and inherited institutions. The approach of working WITH people and if you do not do that gradually finding yourselves doing things FOR them and later TO them (David Jenkins) was a real issue when many secular donors and some of their supported field workers, impatient to achieve quick results during a (too) brief period of contact, did not allow things to "grow", but forced the development regardless.

These were the years of short term church-related workers, many of which did a good job but compared unfavourably with longterm missionaries that really worked WITH people.

With secular donors everything became easier after Alma-Ata, but the budget situation still forced some of them to favour large projects in terms of "getting rid of the allocation for each year so as not to have the budget cut for the next". This meant, as stated above, a growing need for good projects.

Relationship to WHO

The first time Mac and I went to WHO on behalf of CMC we came back feeling like two poor church mice in front of the Archbishop. In the late sixties there was not much understanding for NGOs generally, and even less for church-related NGOs. Not only socialist countries but also others were negative or hostile to

churches and their influence on secular affairs. On the other hand one was not fully aware of the size or impact of the church/mission-related health sector in so many countries.

When we in CMC and together with our friends in Rome put together the statistics of some 1200 hospitals, 400 nursing schools, ten medical schools etc., one began to listen in a different way. The same effect came from the admission by some (not very many unfortunately) secular political leaders, e.g. Ministers of Health, that they could not cope without the churches and missions.

An obstacle to such admission and real partnership was and still is in some places the fact that the ability to limit one's area of responsibility in a church-related programme gives a more favourable position than a government official or agency that has to be responsible both TO and FOR all. The privilege of being able to limit the number of those for whom one is responsible makes it possible to improve and provide services that make even slowly improving government services compare badly. This hurts anyone who is responsible but is not given the resources to exercise that responsibility. This situation is unfortunately aggravated by conscious or subconscious arrogance on the church side. This issue is by the way becoming of acute interest now with increasing privatization and growing expectations on the private sector, including the church-related involvement in health care. - Is one ready to die in order to be a carrier of life? - or is one falling for the temptation of triumphialism?

In WHO as well as in some other agencies there were allies, such as Halfdan Mahler, Ken Newell and others, often clergy and missionary children with a love-hate relationship to the church and its manifestations. They responded to what to them seemed to be signs of christians concerned with the relevance of their beliefs with the realities of the world as they also saw them, in this case the health situation in the world of the dispossessed.

CONTACT was made required reading for heads of departments in WHO and Mahler asked them at a staff meeting: "Why cannot we in WHO do what this little outfit across the field is doing?"

For the book "Health by the People" published by WHO, many of the examples were provided by CMC and from programmes supported by CMC-related agencies,.

Later the general attitude to NGOs was beginning to change. As soon as you earnestly and honestly try to "provide services" or preferably enable people to become responsible for their health and well-being, you quickly realize that you need all hands on deck and even then cannot always cope.

The changing attitude to NGOs and the private sector was therefore a sign of real acceptance of "decentralized ideologies" and healthy humility on the side of those who had thought of themselves as THE providers.

NGO cooperation

With more and more large international policy-shaping conferences taking place, cooperation among international NGOs increased. They started to take part in the planning and preparation for such conferences, beginning with Alma Ata, and then Rio, Stockholm, Ottawa etc. and then took an active part in them. The follow-up was sometimes better in the NGO sector than on the Government side. - Many suffered from the syndrome expressed by David Jenkins returning from the Lambeth conference: "Yes, everybody was for change as long as it made no difference" - to me, I sometimes add. From the beginning of such NGO-cooperation CMC played an active role both in and among those based in Geneva and in the broader international field.

Christian Medical Commissions Contribution in Latin America

by Mabel de Filippini

To understand the significant contribution that the CMC has had in Latin America during 25 years, we have to know the historical process in which CMC has arrived and has developped its work.

We can define three periods in the relation CMC - Latin America.

The first one corresponds to the decade of the 70es, when CMC was launched, and it includes some consultations and the first numbers of *CONTACT*.

The second period corresponds to the decade of the 80es, with a very important meeting at Quito in 1982.

The third period is the present decade, the 90es, with very different circumstances in Latin America, Europe and the whole world.

FIRST PERIOD

In Latin America, the decade of the 70es was one of severe contradictions: In the countries of the South (Chile, Paraguay, Uruguay, Argentina) there were militar dictatorships that used torture, imprisonment and the methodology of missing people as daily instruments to restrict popular movements and to kill their leaders: workers, farmers, University students, women and men, and also their children.

In the Andean region (Bolivia, Peru, Ecuador, Colombia) with a very important indigenous population, there were strong indigenous movements to rescue their rights to lands and culture, but with few results. Peasants, miners and community leaders were killed or put in prison. In some countries there were military governments, in others civil governments, but the whole situation was very uncertain, with little stability.

At the same time, in Central America, in Nicaragua, the war between the popular movement and Somoza, the dictator, was ended and Sandinist forces seemed to obtain success. A reconstitution period had begun and several Christian leaders had played an important role, especially in education and health.

But in El Salvador and Guatemala the war had begun and "guerillas" (military sectors of popular movements) launched their struggles against governments that used their army to maintain unjust social and economic structures that oppressed people, especially the poor.

In the 70es, Cuba had developped health programmes that assured people's welfare for several years.

It is important to emphasize the significant role played by *CONTACT* in that period. It was one of the main publications to make known principles and practices that contributed to see Health as a basic human right and to value peoples participation in decision making processes.

So, in several countries, *CONTACT* had had a strong influence to maintain alive the struggle and hope of many professionals and health workers that believed in democracy and had resisted pressures against their life's option for people.

Some time ago, Dr. Ines Sarli from Argentina told us that in the 70es, under a military government, several medical doctors and nuns in the government hospital where she was working had received some *CONTACT*

issues, and they had passed them on to others with some fear but with the feeling that *CONTACT* articles were so valuable that they had preferred to run some risks circulating the journal.

Otherwise, the CMC's emphasize on Primary Health Care has promoted many professionals to put into practice PHC. So Dr. Julio Monsalvo (Argentina), a medical doctor working in the 70es with indigenous people, has produced several brochures in Spanish and Toba (Indian language), for the training of indigenous health promotors. Also at Guatemala, in 1978, the Ecumenical Committee called Dr. Sarli and Rev. Norberto Sarli to give training in Primary Health Care to rural pastors as health promotors.

At the same time, several groups and health workers had emerged in Brazil, that denounced the abuse of medication and worked in the identification and rescue of popular medicine and medication.

In few lines: During the 70s, the CMC has contributed to maintain up-to-date professional training and to give new hope to people struggling for health as a human right in Latin America.

SECOND PERIOD

In the 80s, democratic forces had succeeded in the southern part of Latin America, and people could elect their governments. But in the Andean region - especially in Peru and Colombia - emerged coca production, drug traffic and also terrorism.

In Central America, there was a continuous war between the regular Armies and the "guerillas" which devastated the region during ten or more years. Economy became worst, and the Latin American Economy Commission has declared it as the "lost decade".

How was the relation CMC - Latin America in this decade?

In the beginning of the 80es an Ecuatorian Sociologist - Victor Hugo Vaca - was incorporated to CMC's office in Geneva. He had a good knowledge of health problems in the whole region and began to visit several countries and to meet people - from the churches and from the secular world - that were working in different projects.

So, in the River Plate area, which includes Paraguay, Uruguay and Argentina, Vaca's visit gave the opportunity to convocate professionals and health workers to meet and to discuss their problems as people were involved in popular health programmes and also how to approach new strategies in Primary Health Care.

Then, in 1982, the Christian Medical Commission convocated a Continental Consultation in Quito (Ecuador) with the theme of „Integral Health". In that consultation, the CMC was represented by its Director at that time, Stuart Kingma, Victor Hugo Vaca and Melita Wal - who substituted Victor Vaca in the CMC.

As Latin American representatives, we can remember Gustavo Parajón, a well known medical doctor and Baptist pastor from Nicaragua; Orestes Gonzáles, Cuban Ecumenical Council's President, with medical doctors from his country: Celerino Carriconde, a Brazilian medical doctor, Catholic, who was dedicated to the rescue of traditional medicine in the poorest parts of his country, and many other medical doctors, psychologists, nurses, nuns, health promotors, from Ecuador, Colombia, Paraguay, Chile, Uruguay and Argentina. They worked in poor communities in rural and urban areas, with indigenous and afro-american people, with children and women, with torture's victims and with refugees.
In Quito's Consultation, Integral Health was the main theme, but different issues had emerged: how the political and economic contexts had influenced people's physical, emotional and social health; how the churches could provide alternative ways and spaces to create health as a whole, how to confront social and cultural fragmentation with multidisciplinary approaches. Also the consultation had included visits to different projects near Quito.

Its great contribution was to put in contact people who came from different realities and could interchange their experiences with mutual appreciation and solidarity, to arrive at a common view of Integral Health as the "Shalom" announced in the Bible to all people in the world.

A very significant result was the inter-communication that several projects and professionals began to develop. So in the River Plate region there were yearly meetings until 1985 which were convocated in different places: one was in Iruya - in the North West Mountains of Argentina - where a Claretian team had begun a Primary Health Programme with indigenous communities. They had received a small contribution from CMC, and their work was very important to the whole area. It is interesting to mention that at present, as a result of that programme, two members of that team are developping a major one in two provinces including more than 30 communities. It is a programme addressed to poor children and their families in rural areas that combines appropriated technologies with traditional practices and with the rescue of indigenous culture and religion.

There was another meeting in 1984, in Neuquén (Argentina), where the participants from Uruguay, Paraguay, Chile and Argentina shared the daily life of Christian Base Communities during a week.

It is important to add that several medical doctors and other health professionals were convocated by democratic governments in the 80s to launch health programmes that can restitute people's welfare after years of war or dictatorship oppression.

At the same time, church-related agencies as the Latin American Council of Churches and the Latin American Methodist Council of Churches had added health issues to their programmes.

Concerning CMC's contribution to Latin America in the 80s, it is important to be emphasized:

1. CMC has played a very significant role as a "facilitator", offering resources and contacts to people who needed to interchange experiences and strategies and to renew their visions.
2. As a consequence of these meetings several teams could learn new approaches and apply them to their own contexts.
3. The 1989 AIDS Consultation in Brazil gave new opportunities to start several programmes in Latin America.
4. *CONTACT* has re-affirmed its value as a very important way of communication.

THIRD PERIOD

In the 90s, the world situation has suffered great and dramatic changes. Powerful and rich countries and corporations are imposing a global market's economy. Today, we cannot speak of First, Second or Third World. We all live in the same world. But in this world there are two kinds of people: those who receive benefits and those who are excluded.

Latin Americans and the Caribbeans are not exceptions. In our countries there are sectors of the population who can buy all what they need to live a very comfortable life and millions that cannot cover their basic necessities: food, employment, housing, health, education.

At present, our democratic governments are applying the so-called „adjustment policies", inspired by the International Monetary Fund and the World Bank, with the explicit goal of: stopping the high rates of inflation that the region has suffered during the 80s; reducing state's budgets - that maintain heavy bureaucracies - ; obtaining better products with less cost, assuring the payment of the external debt interests.

But these policies have a very high social cost: unemployment increases, governmental programmes on health, education and social service are reduced by 50, 60 or 80%. There are no opportunities for young people. Poor families become poorer and all kinds of diseases have emerged or increased: children's

malnutrition and death; cholera has returned; AIDS has arrived. Social diseases such as alcoholism, drugs, sexual violence or family violence are victimizing women, children, teenagers.

Besides these causes of deterioration in the quality of human life, there are additional ones: deterioration of the environment for the reason of governments policies of selling natural resources such as oil, minerals, water and woods. Rivers and lakes have high grades of pollution. Cities such as Mexico and Santiago de Chile are suffering from smog.

Some figures can illustrate the present living conditions in Latin America and the Caribbean Islands (from World Bank / 1995):

COUNTRY	Life Expectation	Children's Deaths	Illiteracy
Haiti	55	93 o/oo	47 %
Bolivia	59	82 o/oo	23 %
Guatemala	65	62 o/oo	45 %

AIDS is increasing in Latin America, according to World Health Organization, 1994:

1rst.	Brazil	55.894 infected persons
2nd.	Mexico	20.077 infected persons
3rd.	Argentina	5.261 infected persons*

* but national estimations give between 10.000 and 20.000 infected

In relation to health problems, we can ask about the role played by the churches in the region during these last years. There were creative and effective answers to the new situations.

In the case of cholera, one can remember the important work made by an Ecuatorian ecumenical organization that had produced several videos, brochures and other materials teaching how to prevent and to assist people affected. They had used the materials in Ecuador with good success, and they had also distributed them in other countries in Latin America.

Other organizations such as the Ecumenical Development Commission in Honduras or CEPADE in Nicaragua have important health programmes, working with rural communities and supporting their efforts to obtain new health resources, technologies and drugs based on traditional ones.

In Chile, EPES (Programme of Health Education) has applied the methodology and techniques of popular education, using plays very successfully with poor people in Santiago, Concepción and other cities of the country.

CEPEXSOL (Center of Popular Education Exeario Sosa Luján) in Venezuela is another model of this educational approach in rural and urban communities.

There are programmes referring to families' emotional welfare, as Eirene, in Ecuador; to women's health in Argentina and Brazil, and to rescue traditional practices in Brazil, Argentina and Paraguay.

Several organizations working on human rights have dedicated special efforts to physical and emotional rehabilitation of people who suffered torture.

And also we have to mention special programmes on AIDS in Brazil and Argentina.

We must not forget other programmes with indigenous and afro-american people that are including their right to land, to their own culture as a main component in their right to be healthy.

Referring to CMC, it is necessary to mention at least five elements that contributed to maintain its influence in Latin America and the Caribbean.

1. Quito Consultation, 1992, with representatives of several countries and health programmes. It was coordinated by Margareta Sköld, and there were significant contributions from David Werner. This Consultation gave opportunity to identify the new situation in the region and to design some strategies to confront health problems. Unfortunately, those strategies cannot be implemented as we hope, especially for economic reasons.
2. AIDS Programmes with different materials produced in Geneva that were translated and distributed by the Latin American Council of Churches.
3. CMC's support for small projects researching special health problems, and training communities to confront them.
4. Margareta Sköld's participation in different meetings convocated by church-related agencies, ecumenical organizations and non-governmental organizations, sharing experiences and information about this Church Action for Health in the 90s.
5. *CONTACT*'s contribution to re-create communication and communion between professionals, church leaders, community leaders, in Latin America and the Caribbean and with other sisters and brothers all over the world.

Finally let me add some words to express my personal appreciation for the good work developped by CMC - at present Churches' Action for Health - in Latin America and especially in the River Plate area.

I think that CMC has had a very important impact as an element of awareness about integral health, putting in evidence that health is not only physical welfare, but also emotional, social, cultural and ecological welfare.

Also, CMC has provided an open space for people engaged in a common vision about health as a right and hope for all. This space led us to discuss, to interchange experiences, to communicate, to express solidarity. In this sense, CMC has been a space of mutuality and resistance against the forces of oppression.

Finally CMC has helped to clarify that health is part of the Christian message of liberation and restitution of human dignity for every one, women and men, children and elders, white, black or brown.

The Impact of CMC on Health Care in Industrialized Countries

by Christoph Benn

A. The perception of CMC and its publications in Europe with special reference to Germany

It is my impression based on my limited experience of working in health care institutions in the UK and Germany and on a number of discussions and meetings with professionals in health as well as in theology that CMC, its ideas and publications are not as well known in Europe as we might wish. CMC exerted possibly some impact on the Christian understanding of health and healing also in Europe, but was not able to permeate the structures in our Churches and Church related health care institutions let alone the government organizations.

DIFÄM and people related to our institute were obviously an exception as DIFÄM was deeply involved in the work of the CMC from the very beginning. But exactly because members of staff of DIFÄM constantly tried to carry the ideas of CMC and its network into our congregations, Churches, academies and health care institutions they also know very well how difficult this task was and still is.

It would not come as a surprises, if only government health institutions did not take notice of what was happening in the ecumenical world. But if theologians, students, nurses and doctors searching for the Christian meaning of health and healing were not aware of the work of CMC or did not find the publications particularly helpful, then we have to ask ourselves: Why is this so?

Is it just a problem of communication, was the wrong terminology used or are there deeper reasons? Were the questions and problems prevailing in the more industrialized countries not really addressed? Probably it is a mixture of all of it and I will try to analyze in this short presentation the factors leading to these limitations as I see them.

B. The limitation of the impact of CMC in Europe

1. Thesis:
CMC was mainly occupied with the problems of health care in less affluent countries.

This point is quite understandable. It is the obligation of Christians to be concerned with the situation of the least advantaged according to the preferential option for the poor. Health care principles leading to greater equity and international solidarity must always get the first priority on our agenda. CMC has made a great contribution to these issues.

But I do think that this preoccupation should not lead to the neglect of the health care problems in more industrialized countries. First because there are large parts of our societies which are quite disadvantaged as well lacking equitable access to health care and therefore deserving special attention of the churches. Secondly the medical model which is so dominant in North America and Europe serves as a universal model influencing health care professionals and decision makers all over the world.

If the churches wanted to suggest a different model, they would have to challenge the health care systems in industrialized countries as well. All too often PHC continues to be thought of as a system good enough if you cannot afford anything better. But PHC as a health care system which is accessible to all, affordable and effective does not depend on economical conditions. Therefore CMC should intensify the study of PHC being the basis of health systems all over the world with particular emphasis on the growing problem of health in the cities.

2. Thesis:
CMC had considerable influence on the formulation of WHO principles and strategies. Contrary to its impact on global health care the influence of WHO in the European countries was very limited. Therefore WHO has not been a good transmitter for CMC ideas in industrialized countries.

The impact of CMC and affiliated institutions on WHO has been well documented. This concerns the European Region as well. If we look at the Regional Guidelines leading to „Health for All" published by the Regional Office of WHO for Europe in Copenhagen we will find many aspects which were advocated by CMC and the ecumenical health and healing movement. These guidelines of WHO for Europe are the attempt to put into practice an approach to health care based on equality, community participation, multisectoral cooperation and the priority of prevention. The guidelines take into account the social, economic and ecological factors influencing the health of people. I do think that a number of these guidelines are debatable because the way they are put they sound rather simplistic and idealistic. But the problem is not a serious debate of these guidelines but the almost complete lack of it. Mostly our health care officials have not even bothered to discuss them as they felt that they were not relevant for their current questions and problems or because they were a threat to the dominant philosophy of medicine. This, of course, has to do with power structures, financial interests and our educational system in health care.

Therefore we should not be too surprised that also the ideas of CMC which are in many ways similar to those of WHO were not recognized in a proper way. Certainly the CMC should also cooperate with the regional WHO offices, but the formulation of an appropriate strategy must be more specific and adapted to the health care problems in Europe.

3. Thesis:
CMC used some specific terms in its publications which have a different connotation in Europe.

Several terms have been of particular importance in the discussion of health and healing within the ecumenical movement. These terms were instrumental in communicating new ideas and in challenging the churches to adopt new approaches in health. These terms are of extreme importance but sometimes they have either not been understood properly in the European discussion about health and healing or they have taken a different meaning.

Justice

Justice is quite rightly a key word in CMC publications. The 1990 Report on „The Churches' Role in Health" starts with the statement that health is a justice issue. There is no doubt for me that this statement is correct. But I do have doubts whether this statement was completely understood, e.g. in Germany.

Distributive justice which is mainly concerned here is used to describe a certain quality of interpersonal or intercommunal relationships. But these aspects are not well perceived in a model of health and an anthropology which leaves little room for factors outside the individual person.

In countries claiming to have a welfare state providing health care to all citizens few health professionals accept that injustice might be a contributing factor to ill health. And even if some people would agree that factors like housing and working conditions, income and social status do influence health, these factors would be considered as being outside the influence and competence of medical professionals which is quite correct in actual fact. They belong to the sphere of the politicians or at most to the public health officials who have traditionally a rather low prestige in Germany.

Therefore I do suggest that first of all we have to work hard to convince people in our countries of the importance of justice issues for the health of people. The consequences will look very differently depending on the type of health care system in a particular country. Justice issues and the problems of inequality vary considerably between countries like Sweden, Germany or the USA with its strong emphasis on private

enterprise. Only after more clarification and thorough analysis of the complex health structures can the term justice be used and understood as an extremely relevant aspect of health.

Community

A very important term in international health is community. The community is the main focus of health promotion and prevention. Communities are the units within a society carrying a particular responsibility for their own health. People come together to analyze their particular health problems, to find appropriate solutions and to implement health related activities. But unfortunately in the industrialized countries this concept of community does not exist or probably more correct: does not exist any more.

The main focus of health in these countries is the individual person. All curative activities are directed towards the individual often without taking into consideration the social relations in which this individual is living. In Germany there is a new emphasis on responsibility in health, but the purpose is to remind individuals to take stronger responsibility for their own health by avoiding smoking, alcohol, dangerous sport activities etc. The community is not addressed to respond to these problems and does not even provide a structure for meaningful health promotion in highly individualized societies.

The greater social unit concerned with health is usually not a particular community living together in a village or part of a town, but the state with its government institutions. At this level the decisions are made. But this level is not appropriate for community participation.
The only attempts to take over the responsibility for health is in small self help groups which are mushrooming. These people are not linked by family ties and they might not even be living closely together. They share one particular concern which is the basis for common action.
As the concept of community is so different in industrialized countries we need first of all a new understanding and appreciation of what community means in these circumstances and cannot apply the same concepts worldwide.

Nevertheless we also need to reemphasize the value of community in all societies and challenge a purely individualistic health system. The churches with their deep understanding of community could be of great importance for this discussion and it would be desirable if academic theological anthropology reconsidered the relationship between individual and community with particular relevance for health.

Wholeness

The last term I want to discuss is wholeness. From the very beginning of the CMC wholeness was a frequently used term. It expressed the desire to overcome the dualism of body and soul which had been so dominant in western philosophy for a long time.

Wholeness also marked the distinctive difference of a Christian oriented health care institution. It was assumed that in government hospitals people were often not treated as persons and doctors were only looking at the somatic problems of their patients excluding other dimensions. But in church related institutions there was at least the claim to be wholistic, to look at the patient as consisting of body, mind and spirit. This wholistic approach was one of the arguments used to defend the existence of church related hospitals.

Although the use of the term wholeness was much more complex than this description, it reflects an important aspect of wholeness and its use in Christian literature. It is to the credit of CMC to have promoted the understanding of the human person in all its dimensions avoiding any form of compartmentalization and reductionism.

But one problem is that wholeness has been very poorly defined. Therefore everybody can and does use this term as it seems plausible to him/herself. The New Age movement, all sorts of alternative therapists as well as spiritual healers use this term in its own way. At least in Germany the terminology of wholeness leads to more confusion than clarification concerning the specific content of the Christian healing ministry.

I am convinced that in the future the ecumenical health and healing movement will need to reconsider the use of this term. Again there is the need for a theological anthropology defining the human nature in a way which avoids the cartesian dualism and offers insights into the processes of life and death, sickness and health. There are some alternatives to the terminology of wholeness.

One was offered by the German-American theologian Paul Tillich. He described man as existing in a multidimensional unity. In each human being there is a biological, physical, mental and spiritual dimension. Each dimension is differentiated from the other, but at the same time each dimension is represented in all others. Our various ways of healing correspond to specific dimensions, e.g. the physical, social or spiritual dimension. Or to quote Tillich: „The multidimensional unity of man corresponds to a multidimensional unity of healing."

A lot of energy and resources are wasted, if we try to apply methods corresponding to one dimension whereas the problem exists in a different one. This is just one model of theological anthropology applied to health and healing which needs to be explored in more depth and preferably in a multicultural dialogue.

But the questions remain to be answered: What is the nature of man in regard to sickness and health? How do theological and medical concepts of anthropology correspond? How can we apply our understanding of the human being in all dimensions to the challenges in health and healing?

4. Thesis:
The health care institutions of the churches at least in Germany did not take notice of the developments within CMC

The churches in Germany are running a great number of health care institutions. The protestant churches alone have more than 150 hospitals. Together with the Roman Catholic church about 1/3 of all hospitals in Germany are run by Christian organizations. In addition there are institutions for the handicapped, the elderly, home care services and hospices.

This is a result of a big movement in our country beginning in the last century. Some church leaders with a strong vision were feeling the need for institutions with qualified medical treatment which was now available with the scientific progress and nursing care inspired by the Christian principles of love and compassion.

They founded orders for women who devoted their lives to the sick and needy. This was a major contribution to the development of the whole social and health care system in Germany. Up to today many of the church related hospitals are owned by the sisterhoods but they are facing quite a number of problems.

There is a strong competition with government institutions, the sisterhoods are lacking young professionals to join their orders and most of all they have somehow lost their identity in the modern social system of our country.

What is the purpose of a Christian hospital in a secular health system? Can you maintain the Christian ideals and principles, if most of the staff is only marginally linked with church life and is not particularly interested in the background of the institution they are working for?

I do not claim that CMC could or should have all the answers ready for these vital questions. But I recognize a certain discrepancy in the current situation. The church related health care institutions in Germany are definitely in a process of intensive discussions about their future and identity, they are indeed at a crucial turning point of their history. Without any doubt they could benefit greatly from experiences other institutions in the ecumenical churches have made, as these problems are by no means unique.

But neither is there a noticeable ecumenical exchange nor would these institutions probably think of turning to the WCC for help in this situation. However, these institutions do need a new vision of their role in a

well-structured, secularized and pluralistic society and I do believe that the ecumenical movement of health and healing could and should contribute to the development of this vision.

5. Thesis:
The universities in Europe were not really involved in the discussion about the Christian meaning of health and healing

In Europe the discussion of health and healing remained within a rather small circle of people involved in the ecumenical movement or working in church related development agencies. The universities, colleges or academies were hardly engaged in this discussion. There is very little work done on a proper theology of healing although healing is a prominent theme in the New Testament. Ministers in our congregations are poorly prepared to engage in serious discussions about healing with the charismatic movement as they have not developed an alternative vision of the healing process. In our nursing and medical schools healing in other dimensions than the physical one is hardly explored.

To get access to students or professionals in theology, nursing or medicine it would have been necessary to get the support of the academic staff of our universities. But for a variety of reasons this involvement did not really take place. Either the theme was not considered to be interesting enough or not academically rewarding or not relevant for the students.

We have to analyse the reasons for this failure and to try to get the support and the intellectual resources needed to pursue the ideas of CMC in an effective and creative way.

6. Thesis:
The ways of communication for the transmission of CMC ideas were not always adequate for the needs of European health professionals

There have been several ways to communicate the ideas and proceedings of CMC in Europe, e.g. meetings and consultations, books and the journal *CONTACT*.

Outstanding in the 25 years of CMC history were the regional consultations. The European consultation in Budapest in 1986 was an ideal opportunity to involve a variety of people interested in these issues from different backgrounds and various countries. It provided a forum for exchange and active participation which brought the ideas of CMC down to the grassroot level. A follow up of this meeting or another conference with a specific theme might be a new chance for the promotion of the churches' philosophy on health and healing.

Among the books published by CMC or its supporters the one written by James McGilvray probably had the greatest impact. „The Quest for Health and Wholeness" which was also translated into German continues to be a good source of information and is repeatedly quoted in other publications. Apart from this book there has been no comprehensive account of the insights and developments in more than 25 years of intensive debate about healing in the ecumenical movement.

The main instrument of communication of the CMC with its network of friends and supporters all over the world has been *CONTACT*. It has done a tremendous job over the years to publicize innovative projets, activities and encouraging examples in health care from all corners of the globe. I have no doubt that this has been an effective means of communication.

But the same criticism I mentioned before applies here. Few people at least in Germany would feel that *CONTACT* is particularly relevant for their situation. As *CONTACT* is concentrating so much on the issue of community participation, its content cannot be applied easily in societies with a completely different concept of what community is. I am not saying that *CONTACT* should focus predominantly on health care problems in industrialized countries, but there must be a serious attempt to translate the valuable ideas into different cultural settings including that of the more industrialized countries and to promote the dialogue between the different concepts and philosophies.

I am also missing a journal where the foundations, the theological reflections, the theoretical considerations might be exchanged. I am not saying that this should be the role of CONTACT, but I do think that an international ecumenical journal dealing with healing in all its dimensions might be desirable.

I do think that the new structure of Unit II in WCC linking health to education, mission and witness offers a unique chance to broaden our vision and possibly also to provide a platform for the exchange of ideas going beyond the more restricted area of health care projects.

C. Tasks for the future of Christian health care in industrialized countries

1. Care for those most in need

In many countries of the world including the more industrialized ones we are observing a persistant trend towards increasing inequalities between rich and poor in our societies. In Germany we are talking of two thirds of the population who are well off not lacking necessary resources, services and amenities including access to excellent health care facilities.

But one third has to struggle economically and socially and the group of those lacking decent care is ever increasing. This group consists mainly of long-term unemployed, elderly, migrants, asylum seekers, homeless people, drug addicts and chronically ill. I am not saying that this group has no access to health care at all, but gross differences do exist (see Black Report in UK).

One of the most important principles of Christian social ethics is the obligation to care for those most in need. It is not the role of Christians and Christian health institutions to do what others are already doing, to do what looks financially lucrative and intellectually stimulating. Christians have very often been in the forefront of movements which responded to the most pressing social needs. That was the origin of the church related hospitals in Germany. Today it looks as if at least the church hospitals in our country have lost this momentum. We might find it in small groups and institutions looking after some of the disadvantaged groups I mentioned above, but the hospitals are rather indistinguishable from other centres of technological excellence.

I believe that it is time now to rethink the policies of our institutions and to start with the questions of who are those for whom nobody else is caring, how can we make the best use of the enormous resources the churches possess and how can we develop together with the least advantaged a comprehensive strategy for health promotion.

2. Challenge of the current paradigms of health care

Many people all over the world including Germany are talking about a paradigm shift in health care. A shift from curative repair to the maintenance of health, from the individual to the community, from professional control to participation, from body-mind dualism to multidimensional unity, from health as business to care according to need.

This paradigm shift is recognizable but far from realization. The churches and church health institutions will have to contribute to this new vision of health care which is actually a very old one.

3. Multisectoral cooperation in the formulation of ethical principles

Ethics in general and medical ethics in particular have become very important and popular subjects over the last decades. Medical ethics is taught in many universities and colleges and health professionals as well as decision makers and politicians are turning for help to moral philosophers and theologians. This is a

challenge and task for our churches in technologically advanced societies. But the challenge is actually universal and is including the ecumenical movement.

Certainly the churches or the CMC should not become a specialized agency on medical ethics in an academical way. But the WCC and the ecumenical movement have a particular potential and tremendous resources which other academic institutions are lacking. They can bring together people with wideranging experience from different nations and cultures and with different church affiliations but still being able to work together on common ethical principles. With this global and multicultural approach they can avoid a cultural bias and an ethical imperialism which is often the problem with ethical theories originating from one particular philosophical tradition. Such a multicultural ethics is urgently required today.

The challenge of HIV/AIDS is an example for a global problem which requires international solidarity and the multicultural ethics I described. The churches are urgently called to respond to these questions. Therefore the consultative group on HIV/AIDS of WCC was formed and will hopefully become a good example for the difficult task to combine the disciplines of systematic theology, pastoral care, sexual and medical ethics to formulate principles which should be a help for Christians and churches worldwide to develop their own strategy in reacting to this pandemic. In this group there is also a good chance of a fruitful cooperation between Unit II staff and their colleagues from the other units of WCC.

This might be a model for the future work of CMC - Churches' Action for Health as well. It has always been emphasized that health is not only a concern for medical professionals, but still it seems that intersectoral cooperation has been difficult even within WCC. The new structure of Unit II offers the chance to draw more than before on the resources of different departments as well as to receive the support of Faith and Order, JPIC and others to develop together comprehensive concepts of health and healing which are relevant for people living in different cultures, societies, economic conditions and religious traditions. It is my vision for the future of CMC - Churches' Action for Health that this multisectoral and multicultural approach will preserve the original thrust for better and more just health care, deepen our understanding of healing and open up our churches and institutions for a new paradigm of health.

Session: Theology of Healing

1. Devotion
by Aart van Soest

"A devotion is", my old friend Chambers says, " (amongst a lot of other things), the 'state of being devoted' and 'giving up the mind to the worship of God'. So you hit on the wrong devotionist, for I cannot say - with all respect to and kind feelings for what is hidden behind your abbreviated name - that I am devoted to you. Nor does my way of faith rely particularly on the act of giving up my mind.

But on the other hand...

Some years ago the former medical missionary Ary de Geus (he died last year) was given a party, celebrating his retirement from the chair of Tropical Medicine at the University of Amsterdam. Repeatedly he was praised for his role in finding solutions in conflict situations in academia. His great 'idealism' was said to be one of his outstanding characteristics.

In his answer to these eulogies, Ary said: "I must contradict. If I have been of any service in creating understanding and peace amongst us, it was not out of idealism - but I was urged by "biblical realism".

So let's turn to the Bible if we think in a devote way about "25 years of CMC". Somebody has done a piece of work - and time and circumstances allow, even press her or him to ask "what have I done, what am I to do?". If you carry a C. in your name - a dangerous thing to do! - you have to reduce these questions. You have to reduce them to: "What is God's will with us?".

There are examples enough in the Bible of people who "stood at the crossroads and looked" as Jeremiah said it (Jer. 6.16). There was the man **Moses** (Ex. 3), called to his task from the burning bush. But Moses, of whom it is said, (after all! - after 40 years in the desert in fact -) that he knew the Lord face to face - Moses had nothing but "buts":

"Who am I?"; "Who are you (anyway)?"; "...and suppose they don't believe me"; "I have never been eloquent"; "Please send somebody else!"

So many "buts" he had, this Moses, that "the anger of the Lord was kindled against him". And he was forced to see "what was God's will with him." And he didn't like it - nor did he ever reach the goal of God's road: He saw it only, but he did not cross over into the promised land.

And there was the man **Elijah**, the prophet-par-excellence, the true non-compromiser, the terrible religious warrior. No doubt for him, when he is standing at his sodden alter, praying for what he knows is not his, but God's sake: the miracle of heavenly fire - confirmation of the message he had obeyed to bring (1. Kings 18 + 19):

'O Lord - let it be known this day that you are God (...), that I am your servant, and that I have done all these things at your bidding'. And the confirmation comes:

"The fire of the Lord fell and consumed the burnt offering, the wood, the stones, and the dust, and even licked up the water that was in the bench (around the altar)"

And that glorious confirmation is followed by the horrible consequences: the killing of the 150 priests of the false religion, followed by the threat to Elijah by the political powers. And then Elijah - that great man of God - "was afraid; he got up and fled for his life".

The contemplation of his life's work - not yet fully 25 years, I think - was a rather sad affair:

"he went a day's journey into the wilderness, and came and sat down under a solitary broom tree." He asked that he might die: 'It is enough; now, O Lord, take away my life, for I am no better than my ancestors'. Then he lay down under the broom tree and fell asleep. Suddenly an angel touched him and said to him: 'Get up and eat'. He looked up and there at his head was a cake baked on hot stones, and a jar of water" (a buffet or a swabian dinner might indeed have been out of place under the circumstances). „He ate and drank, and lay down again. The angel of the Lord came a second time, touched him and said: 'Get up and eat, otherwise the journey will be too much for you'. He got up, and ate and drank; then he went in the strength of that food fourty days and fourty nights to the mountain of God, Horeb."

Miracles, no doubt - or perhaps to our ears rather: miracles, so: doubt. But miracles to reveal something: Elijah is to experience "the Lord passing by - not in any deeply impressing event (a strong wind, an earthquake, a fire), but in "a sound of sheer silence". And it is from this "sound of sheer silence" that the Lord asks Elijah to consider his ways:

"What are you doing here, Elijah?" He answered: "I have been very zealous for the Lord (...), but the people have forsaken your covenant, and I alone am left."

Then the Lord tells Elijah to prepare for the future: to anoint the new king, to appoint his successor.

There are things to be done, down-to-earth things, in the political kingdom of Israel. And at the end of the road Elijah - is taken away. No trace left of him. His mantle was taken by somebody else (2 Kings 2)

May I still give another example of a biblical figure, contemplating his work under Gods command, and waiting for its future?

My third man is **Jonah**, the son of Amittai, the reluctant prophet. He doesn't protest verbally only against God's calling, but he flatly refuses to do what he hears is God's way for him: "Go at once to Niniveh, that great city, and cry out against it: for their wickedness has come up before me". But Jonah set out for Tarshish from the presence of the Lord - and he knew why! First his Lord has to "hurl a great wind upon the sea", Jonah is formally - at his own request - sacrificed by the crew - the ship is saved and Jonah is saved too, singing psalms, singing "out of the belly of sheol" (hell) like some of the righteous did when they were driven to the gas-chambers of Auschwitz. And again comes the command: Get up, go to Nineveh, that great city, and proclaim my message: "Fourty days more, and Niniveh shall be overthrown".

("Fourty" haunts my story: fourty years desert - fourty days walk - fourty days respite from the Lord's wrath)

And Jonah takes up the message with glee and conviction - and obviously in a very impressive way. So impressive, that (the people of Nineveh) "cried mightily to God, and all turned from their evil ways and from the violence that was in their hands"

"When God saw what they did, how they turned from their evil ways, God changed his mind about the calamity that he had said he would bring upon them; and he did not do it."

But this was very displeasing to Jonah, and he became angry, because he had convictions and principles - mind you:

"O Lord! Is not this what I said while I was still in my own country?" (Not that we heard anything of that before!). "That is why I fled to Tarshish at the beginning; for I knew that you are a gracious God and merciful, slow to anger and abounding in steadfast love and ready to relent from punishing". And that, O Lord, is by no means in accordance with my insights, my dogmatics, my road on which I am - of course - ready to follow you, if you keep Yourself in my boundaries. "O Lord, please take my life from me, for it is better to die than to live".

But the Lord did not argue, he just asked: "Is it right for you to be angry?" And Jonah sat sullenly under a little shade, the cosiness of which was reinforced through another small miracle. "Some kind of recognition from above", Jonah was satisfied to notice. And he waited for the pageant of fire and brimstone. But it did not come. Instead the small miracle withered - and Jonah fell into his sullen mood again: "It is better for me (!) to die that to live": "Angry enough to die"

Then the Lord said: „You are concerned about my blessing - a small miracle - which you enjoyed and interpreted - strictly within the context of your convictions and beliefs of course. And you think that is right. Well, be it so - but then: should I not be concerned about Nineveh, that great city, in which there are more than a hundred and twenty thousand persons who do not know their right hand from their left, and also many animals?"

A man again, on his knees, before the pending annihilation of his work - if he is but the man Jesus before the annihilation of our shyness (Moses), stubborness (Elijah), conceited righteousness (Jonah), if he is Christ.

„My God, my God, why have you forsaken me" - the cry of Jesus Christ.

I was taught in my youth that Sundays and Christian holidays were to be celebrated, because they were manifestations of god's gracious word. Secular anniversaries - birthdays, new year's eve, 25 years of something or other - were but reminders of fleeting time and, in a sense, of no concern to us, except for the possibility of contemplating what we ought to do with that „time of God's grace".

It was - I presume - for that reason that at that little ripple of time after a year had past, we read the 90th Psalm (said to be a psalm of Moses), a great witness to the futility of our lives, as measured against God's everlasting faithfulness. But also a Psalm, pertaining to our work in time past, present and future. The last verse (17) reads:

„Let the favor of the Lord our God be upon us, and prosper for us the work of our hands - so prosper the work of our hands."

So be it.

2. Summary and Discussions

On Sunday 22 January, ***the Fourth Session*** began with a meditation by **Aart van Soest**. **Daleep Mukarji** was the moderator.

David Jenkins gave a presentation on "***The Christian Healing Ministry Today***" though he began by saying this was an unsatisfactory and misleading term in relation to the issue today, because the basic model we have, which we think we get from the New Testament, no longer works. "I don't think CMC has ever worked out a clear alternative view of the Christian Healing Ministry today which can be clearly related to a responsible Christian use of the NT tradition." So we find it difficult to give a clear account in church circles, or indeed to ourselves, of the central motivating force of the concerns we have: how do we justify our concerns about the realities of the encounter today in modern medicine, medical practice, modern health care problems, modern uses and abuses of medicine - together with our concern for justice in the provision of care for the sick and the distressed?

It is clear that we are committed to it, and that we do this as Christians, but we have trouble explaining it in ways which are convincing to the ordinary person in the pew. It seemed to me - and now I believe I was right - that it is necessary to face this, because on the one hand there are pressures from the churches (why do you get so secularised, why don't you simply go for the signs of the gospel which are spiritual, powerful, converting and decisive, and add people to the church), and secondly, looked at from the other way round - our message doesn't get over to the churches: why don't they look outwards, why don't they speak up in these situations, why don't they get on with a ministry tackling this sort of thing?

Therefore it seems to me essential as we move from discussion to formulating action that we ask ourselves: What is the central significance of healing episodes and miracles in the NT? My thesis is: they are signs which from the beginning have been rendered wondrous signs = miracles. But what are they signs of, what is the message they point to, and what is to be received through them? It is by no means clear that nowadays a healing miracle is a sign of Jesus and the Kingdom; nor was it so in NT times, if people would only read the Bible carefully. Much of today's healing ministry looks superstitious, turned inwards, reinforcing the notion we are up against in a technologised world - that religion is superstition. It does not speak of the Kingdom of God, and the central biblical and theological and discipleship point we have to grasp is: What is the message of the Kingdom of God?

We are Christians because we believe God raised Jesus from the dead, and this is the Jesus who proclaimed the coming of God's Kingdom and made it clear by word, action, life, message, by the whole directing of his living, that he was wholly committed to the service and obedience of the Kingdom, even unto death. And he taught his disciples to pray to God as Father, for the coming of the Kingdom. We use the prayer today: but do we live it, feel it, see the point of it? For this coming of the Kingdom and in this praying to the Father, because of his faith and obedience to God his Father, Jesus died. His faith was total, his commitment complete, and his obedience ultimate - in the literal sense of each of those terms. The result was death.

But we know that this was not the last word about Jesus because the spirit of the risen Jesus, the Holy Spirit of God the Father, has brought us into the company of those who know that Jesus is risen. And we know therefore that Jesus was absolutely right in his faith, his proclamation, his obedience. God is and is indeed our Father, the one who cares, who sustains, who over-rules; our Father who builds his Kingdom of love, justice and peace - to be interpreted in the broad biblical sense: all-embracing love, justice which is shalom, joyous living together. The powers of the Kingdom are available now in the midst of our unfinished and troubled world; the promise of the Kingdom is there and will be fulfilled in the end. The human picture in one sense never changes, you never give up. It is realistic - we have a gospel to proclaim, to live by and to celebrate, and this is the gospel, the good news of God through our Lord Jesus Christ in the power of the Spirit - and that's the message which anything you do as a Christian, in any situation, institution, profession, is to be signed, to be given wonderful signs of but more often very ordinary signs, but because they are related to the Kingdom become extraordinary, even more loving than the loving which is so much around, even more ready to face death and endurance, the amazing readiness to face what is happening in Sarajevo or Rwanda.. deepening the ordinary into the extraordinary - here is the presence of God, the promise of God, the suffering of God, the caring of God.

And so the question is: What might this means for us in CMC where our concern is with Christian witness and service within the fields of sickness, medical activity, health care and health care institutions? Any future of the CMC must be rooted there, and worked out in such a way that it does not become concerned with everything and thus says nothing. The great glory of Christianity in the Incarnation of Jesus Christ is that the universality of God is a particular person. The sacraments are given into the very particular hands of each one of us - evil hands, sinful hands, useless hands - the actual presence of God makes us, each one of us, in each moment, a messenger, a sign, a servant, a sharer, a celebrator, of this universal Kingdom - but always down to earth because of Christ.

Therefore we should transpose our question: not, what is the Christian Healing Ministry today? but What are the contributions which Christians today are called to make in this field of sickness, medical practice and health care? Where do we go from here in speaking of the Kingdom in the present situation? Jesus is the Word and Son of the one and only God whose creation, care and Kingdom are to do with the whole earth from the beginning of creation to its end, and for this very totality the Kingdom is to do with all peoples in general and every person in particular, and that is where you come to the challenge to Christian witness in this field.

Here are three ways into thinking about this: When men and women fall ill, they are called in question. When they are ignored and forced into poverty, they are called in question. When they are condescended to, they are called in question -they don't count. The point is this calling in question and how you respond to that. I suggest there are ways of service, of sacrament and of challenge.

Service is where you start because that is where you serve the individual in the particularity of the case. Of course, conversely, for Christian witness, you know that nobody is a case, but unless you take very seriously what they are a case of, you are not taking them seriously as they are in their circumstances, so you don't write off all the medical particularities and the pharmaceutical necessities, etc. But they are to serve this person and their family, wherever they are, in their need of the moment, so that they may be affirmed and cared for and may be put on the way to greater enlargement. So the service is something we long to share and to offer, and it is a loving and lovely thing to serve one another and to receive the service of one another - because we are loved, because we are made for love, because we long for love, and because we are to be fulfilled with love. Loving is the one thing that multiplies inevitably and indefinitely and eternally. There is always room for more love; it binds us closer together.

And service is not to be given because it is a duty although duty comes into it; it is not to be offered because it is a responsibility though responsibility comes into it - though you must beware of feeling so responsible for people that you tell them what to do. So responsibility is an expression of love; service is to be offered because it is at the heart of the praise and the glory of love - and that is what has an eternal and everlasting and undefeatable future. I wanted to sound this note of devotion, because unless we inform all our discussions with the possibility of worship, unless we are clear that mercy is more important than justice - misericordia - having a heart that cares. It doesn't wipe out justice, it broadens it. But you can be very just in a very terrifying way.

It is not rhetorical to be devoted. Unless you can really begin to enter into devotion - and we need reminders, we need to learn our devotions together - there is no informing of all these things with the love of God, and the power of the Kingdom. It isn't rhetoric - it's a matter of practice, how you actually care, how you speak by what you do and by how you use things like drugs, interventions, etc. It is very important to restore this sense of calling; everyone is becoming either so cynical or operational or functional, that you end up not treating people as people. And to bring back this loving sense of possibility, to be aware that the God whom we serve is the only power in the world and beyond the world who doesn't care for his power except to the extent that it helps people, and is ready to give himself away.

So this has got to be brought into our practice. It leads on to the ***sacramental***, in this broad sense. Ordinary things, bread and wine, the sign, not a re-presentation literally but a re-presentation in all its dimensions of the very being of the body and blood of Christ, his life, given. Similarly one must begin to try and understand one's serving in this broader dimension - and that means of course that our ministry must be challenging, because we have to criticise all those things, where the treatment of people in sickness adds to their questioning rather than building them up. And CMC knows a lot about this, analysing communal, social and political aspects, health care, practice of medicine, what pharmaceutical companies do, and so on, which turn things from being sacramental into distorted exploitation, putting people down.

So you go from service to sacrament, and from sacrament you come to ***challenge***. And this is where our whole ministry is so important: to restore the challenge of the Kingdom which is really the challenge of the divine possibilities of human beings, men and women and children wherever and however they are: this is what the heart of the world is about, and this is what the practice of the profession is about, this is what using our immense technological possibilities is about - it is amazing what we can do if only we would offer it. It is a gift, but a gift of life. So we must challenge the political, the professional, the despairing, the wrong use of technology, the absurdness of making everything so expensive that nobody can pay for it. We have got to restore through our service, through our use of sacramentality, through our readiness to challenge -this message that God calls us to turn away from all the distortions of humanity in the world towards the collaboration and the caring of the Kingdom, and this he does in a down-to-earth way: he doesn't call us to the impossible though he calls us to the unfinished, because he gives us the Spirit - he is with us: God is greater than great, God is more loving than love; God is closer than close -that's what the truth is about. God is with us, in us, between us; we are God's servants. And this is simply true.

And so I would argue that if we are to serve God today, we don't have to go in for distracting signs and wonders that people will think are superstitious. Just be thankful and get on with the task. The signs we are seeking to bring about through service, sacrament and challenge, will not be immediately recognised by the churches which are falling back into "religion" because they are so frightened by the world, nor by the structures. But God still gets through - even the church cannot keep a good God down. And so we have this calling to work out signs of the Kingdom through service and challenge, and above all, in common praise. Whenever you are stuck in a problem, first be thankful and then see where you go from there!

It becomes clearer to me that if you really believe in the God of the Bible, the God of the Jews, the God of Jesus, the God who is the Spirit, then there are two places where God is: in his own place, and right here. If you believe in God in this realistic way, which you can't do very well but it's what you are called to do, then it follows that not that it is his will that I should be here (because he's left all sorts of spaces for us), but once I am here, he can do his will.

Sylvia Talbot took the issue with the point about CMC concentrating on institutional forms of healing. If each person has a ministry of healing, if healing means mending brokenness, stitching together to make whole, then each person who claims Christ should be ministering in that way. The healing ministry is surely a ministry of the people of God, and we talk about those people in terms of a congregation. And then we also say that brokenness is not mended by medical intervention, so if CMC is going to really help our churches to heal, then it has to help them understand what their ministry of healing is - and that means using the instruments of healing they have: worship, the sacraments, caring for the bereaved. In a congregation people are healing in all sorts of ways; we need to have them understand that they are healing right now, but there are other ways in which they can support professional people in their healing.

David Jenkins responded that in trying to state the problem he had tried to face the question of the universal as opposed to the particular, and to say that the way we balance it out should always be worked out by reference to the Kingdom.

In response to a question about what he meant by "superstition", **David Jenkins** explained that when superstition is reflected back on oneself and is self-contained to a point that it does not take you through to the liberating power of God, one becomes trapped within what is really an idolatrous view. Some people are too "religious" like for example the experience of Paul in Athens when he found the altar to the unknown god -which was established arbitrarily, as a protection in case they had missed one out, not from any positive desire to worship God.

Ana Langerak said that in early CMC literature there was much reference to sacraments, and she felt it important to recover a sense of such down-to-earth realism again that we can underline in the healing ministry. What is the relationship between sacrament and sacrifice? Perhaps we should see what this means for our work today. And what is the relationship between sacrament and challenge? What might the challenges be?

In practice, **David Jenkins** felt that sacrifice was a matter of limits. How is the "first world" going to face limits of the kind that already exist in the "third world"? You never know which limits you might be able to transcend; you do not necessarily give up because a problem seems insoluble.

On the question of sacrament and challenge: we seek to use the ordinary things -water - to be blessed by God so that it can be offered to him and transformed. Once it has been turned into something that can be shared with others, it challenges your use of material things, your use of power - the way you make use of medical knowledge, your capacity for technology. The sacramentality of the world challenges us all the time.

Rainward Bastian referred to David's advice to "stick to our limits", and to give thanks. As citizens of the rich North, how can we give thanks for this problem? David explained that staying rooted in your own area of calling and experience is precisely to give yourself credibility and authority when you speak more widely. "Sticking to your limits" provides you with the means by which you can address economists and politicians because you can speak from your own built-up knowledge that you are rooted in. And the gospel will give you courage to risk using this credibility and authority as a challenge. One of the risks is that people will cast aspersions on your expertise, so you have to be very clear on what you are saying.

The matter of giving thanks is a sensitive one: praising God in the midst of so much bad in the world is a challenge to us and a challenge to faith. One gives thanks for God and his existence and the signs of his presence; we give thanks as guilty sinners who can give thanks because God is and because we are forgiven, but out of thanks and praise must come action: without repentance, thanksgiving is empty.

Hakan Hellberg sounded a warning about the real danger of medicalising the healing ministry, as has happened in the case of PHC because it was convenient to let this happen. We must not fall into the reductionist trap. We need to keep a broad base, and keep everybody on board and avoid a narrowing down, because nobody else has the responsibility for this sector.

Birgitta Rubenson highlighted the importance for CMC of keeping this base of health care institutions: that is our base and that is where the brokenness is manifested. We cannot do the whole task ourselves but should inspire others to be part of the healing process. We have a role related to sickness and health care but if we do not keep in touch with the base we become no longer relevant to many people. That is why CMC has failed sometimes and why we have not been recognised as having an answer.

Sylvia Talbot said she had understood that CMC was moving away from focusing on institutional care: that is not where ill health can be corrected. Surely, in changing CMC's name to "Churches' Action for Health", this implies that the churches have a responsibility in health matters. Who is able to help the churches accept their responsibility here if not CMC? We have to talk to the people, not to the institutions.

That is why we must not try to do everything ourselves, as medical people, responded **Birgitta.** We have to realise we are only one part of all that needs to be done to heal the community. The way we use healing is really salvation - healing all kinds of brokenness. It is more than what CMC brings into it; we have to see that others have a part to play too. We have a specific knowledge and experience that we must use as our contribution to healing communities.

Nita Barrow explained that the term "institutionalise" was not correct - rather, it is a question of the medicalisation of care. In the beginning CMC was endeavouring to help people - all of us - to accept responsibility for healing in a total sense, not just in the medical sense. Where communities still see health in terms of institutions, there we have failed to motivate people to take charge of their own health in the whole sense of the word.

Jack Bryant asked David to reflect on the critical question: What is the nature of the challenge we are responding to? How broad is the base that we call "ours" and within which we would like to develop? Our challenge is to identify the way in which individuals, communities, populations are dehumanised or broken. We know that the pathology there is highly varied depending on the place, the problems, the people involved. Secondly, our base must be broad enough, our credibility must be stronger to respond to the challenges we are identifying. We know that PHC is an important means but without institutional medical back-up it is compromised. Yet, without outreach, the institutional medical system will not succeed. We have to understand, and learn how to work with the churches in bringing in their resources.

Responding to some of the points raised, **David Jenkins** explained that there cannot be an overall answer about the way we respond to challenges: you have to set out the various pressures that need to be balanced out and see

how they can be worked out practically. This applies to the future of CMC in relation to the rest of Unit II - what particular contribution CMC can make. The question about how particular, over against how broadly based you should be: again it is important to find a balance between the need to be very particular indeed because people must be enabled to respond to the Kingdom and to their possibilities in the situation they are in, and being very universal indeed in our vision because God's love is overall and for all. So you must start from your specific base without being apologetic about it. Then, between the particularity and the universality, you must have thrusts - enlargement and openness. You have to reach a point where you decide what tasks to concentrate on, and in working out each task you must ask questions to ensure that you are not getting too institutionalised.

Jim McGilvray's great notion was enabling the congregation to be a healing community in both senses: places where people receive healing but also as a basis in the community for healing outwards. This is a difficult notion to get through to the churches in the West who simply do not relate to this, except in a few cases.

Finally, the gospel has no meaning for so many people today, because it talks about a God in whom it is difficult to believe and tells stories which are not very down to earth - for the reason that the churches are not prepared to be engaged in places where people are really threatened as people. For CMC, this means that it must be deepened and reinforced, not narrowed down, but to do this it must locate itself.

3. Presentation

The Christian Healing Ministry Today

by David E. Jenkins

I must begin with a confession. I find the phrase "The Christian Healing Ministry" increasingly misleading and even distasteful. Indeed I begin to suspect that it is worse than useless - for it is too often associated with overtones of superstition, sectarianism and self-indulgence. You may think therefore that I am here under false pretences and abusing the amazing hospitality of DIFÄM which I personally have enjoyed on and off for very nearly twenty-five years. Perhaps I should never have come.

I hope, however, that I can persuade you otherwise. For I believe I have never wavered from my commitment to the central concerns of the CMC. It is the word „today" in my title which gives the clue to my worries. It seems to me that far too much of the talk and the activities which go on under the label - or indeed the banner - of „the Christian ministry of healing today" is today, whatever may have been the case in earlier times, liable to obscure the Christian message and to hinder the spread of the Christian Gospel. This is a hard saying and I must ask for your trust, patience and attention as I try to explain why I feel compelled to utter it.

I find the phrase „the Christian healing ministry" awkward and embarrassing because I have come to the conclusion that it usually indicates an unreflective transfer of thought and imagery from the New Testament into the field of Christian witness, service and ministry today within the field of sickness, health care, medical activities and health care institutions. When Christians talk about „the Christian healing ministry" I believe we all tend to start from what we hold to be a simple and obvious New Testament image and type of event. This is the class of events which we call the „healing miracles" of Jesus in the Gospels, repeated, as we believe, in healing episodes in the Acts of the Apostles. „The Christian healing ministry" is held, basically and definitively, to lie in the repetition by Christians as we encounter sickness and disease in individuals today of something parallel to, or echoing and imaging, these healing miracles.

Therefore we at least subconsciously assume that a Christian healing ministry is a ministry to diseased or disabled or otherwise distressed individuals whereby they receive, through prayer, the laying on of hands and anointing, the capacity to be cured of their ills or to be enabled to live with them in new and life-giving ways. Thus, in many parts of the church in many parts of the world, we are exhorted to recover and renew the New Testament healing ministry by special healing services and activities. We are further told, by not a few persons and groups - especially among the Charismatics - that this healing ministry can indeed multiply „signs and wonders" which have a compelling, attractive and converting power. Much is made of particular persons, or forms of service and ritual, who or which have special powers and possibilities in this respect. Here, we are told, is the authentic renewal and availability of the New Testament healing ministry. This is indeed THE Christian Healing Ministry Today.

I know that this approach has not been uppermost in the thinking and attitudes of the CMC, but I do not think that the CMC has ever worked out a clear alternative view of the Christian Healing Ministry Today which can be clearly and powerfully related to responsible Christian use of the New Testament tradition. So we find it difficult to give a clear and compelling account in ordinary church circles - or indeed to ourselves - of the central motivating and directing force of the concerns we have always had in the CMC. How do we justify the concerns we have always had about the realities we encounter today in modern medical practice, in modern health care problems, and in modern uses and abuses of medicine, together with our concern with justice in the provisions of care for the sick and the distressed?

The issue I am trying to state and face is urgent for us as we seek a ***Vision and Future*** for the CMC for two closely interconnected reasons. The first is that we are surrounded in the churches by many signs of what is claimed to be a revival of the Christian healing ministry in the spirit and the power of the New Testament, as I have already indicated. We are liable therefore to be pressurised by the churches whom we seek to serve, whose mission we are deeply concerned to promote, and on whose support we rely. They are liable to urge us to focus our efforts more (and perhaps more and more) on this area of „authentic Christian healing". Concern with healing signs and wonders is, so it is alleged, so much more simply and clearly New Testament and „spiritual" than being so much involved in the secular concerns of details of medical treatments, problems of health care delivery institutions and issues about the justice of the availability and distribution of health care treatment. In these latter concerns we are in danger of being so secularised that we have no clear gospel emphasis or witness.

These pressures and possibilities challenge us - and indeed the churches - on a very central issue about Christian discipleship, Christian mission and witness, and Christian proclamation of the Gospel today. This is the second and more important reason why the issue I am trying to put before you is so very urgent for us and for the CMC as we seek for „the vision and the future" as the vital part of our celebrations of twenty-five years of CMC. It goes to the heart of the existence and the operations of CMC, it also goes to the heart of the personal Christian discipleship of each and every one of us. For it faces us with the question: What account do we give (firstly to ourselves and then to others) of why we seek to promote and follow the programmes which we undertake? How do we justify the claim that what we seek to do is a vital part of the Christian healing ministry today?

To answer that question we have to have some fairly simply and reasonably widely shared view of what is the abiding nature of the Christian healing ministry from New Testament times to today and into the future. Do we have any other model for what is at the heart of Christian healing ministry than the New Testament one, understood in terms of signs and wonders effected by prayer, the laying on of hands and anointing, and related directly and solely to the improvement of the diseased or uneased sufferings of particular individuals?

I have come to the conclusion that we must have another account of the Christian calling and ministry with regard to healing in the field of health care if we are today to be faithful to the New Testament. The critical point is this. We have to be clear that finding the basic model for a Christian healing ministry today in attempts to pursue, promote and make Gospel propaganda for healing signs and wonders which are believed to be repetitions and re-presentations of the healing episodes or miracles of the New Testament, is not to re-present the gospel message of the New Testament to the people of today. Rather it is to obscure, hide and put up obstacles to the presenting of the Gospel of God in Jesus Christ in more and more of today's world. Indeed many of the manifestations and attitudes which accompany this „signs and wonders" approach display superstition, express sectarianism, and encourage spiritual self-indulgence.

The issue is urgent. It is also disturbing. For it probes deeply into the way we perceive and receive the message and power of the Gospel through our reflective and faithful reading of the New Testament. Ask yourself, therefore, what is the central significance of healing episodes and miracles in the New Testament? They are SIGNS - semeia - as they are regularly designated in the Gospel of John. The question is always what are they signs of, what is the ***message*** which they point to and which is to be received through them?

As is well known this issue of signs and messages was a contended one in the ministry of Jesus. There is the famous and significant occasion when the Pharisees said: „It is only by Beelzebub, the prince of demons, that this fellow drives out demons" (Matthew 12, 24ff and parallels in Luke 11, 14ff). The challenge lies in the subsequent words of Jesus - „But if I drive out demons by the Spirit of God, then the Kingdom of God has come upon you". This makes two things clear about the miracles and healings of Jesus. Firstly, they raise a question and there is the crucial need to perceive the message. What is this wonder a sign of?. Secondly, the message is about the Kingdom of God. This - the message about the Kingdom of God, is the crucial point around which I wish to build my positive proposals for our future CMC approach and programme.

But first I must also remind you of further evidence that the Gospels are ambivalent about the signs and wonders. Further they attribute this ambivalence to Jesus. We may compare, for example, the saying of

Jesus reported in Luke Chapter 11 (the same chapter in which the Lucan account of the Beelzebub incident occurs). „As the crowds increased Jesus said, *this is a wicked generation. It asks for a miraculous sign but none will be given it except the sign of Jonah*". This echoes the powerful discussion in Mark chapter 8, which begins: „The Pharisees came and began to question Jesus. To test him they asked him for a sign from heaven. He sighed deeply and said, "*why does this generation ask for a miraculous sign? I tell you the truth, no sign will be given it*". (Mark 8, 11 f).

The evidence from the Gospels in the New Testament is therefore clear that healing signs, episodes or miracles are not significant simply and solely because they happen. Their happening raises questions about their agent (who is it that is the focus of the episode?), about their context and about their longer term meaning and promise. They are neither self-explanatory nor guaranteed to produce satisfactory or, in the longer term, desirable results. There are therefore ample grounds in the New Testament records themselves for being very cautious about any simple minded supposition that a mere repetition of miracles, like wonderful or unexpected healing episodes, is automatically a transfer of the New Testament message about Jesus to the present time.

On reflection this should be quite obvious to us in any case. For now that we come together as Christians from a world wide variety of cultural contexts and traditions we must know that claims to healing miracles or the activities of spiritual and inspired healers are not at all confined to Christian contexts and activities. It is simply not the case that an episode of spiritual or miraculous healing automatically and necessarily carries a face value and message about the personal significance of Jesus as the Christ, or about the Kingdom of God. An episode of healing solely as such is simply an episode of healing. It may be received in a variety of contexts, experienced in a variety of ways, and understood both by the subject and by participants and observers, as conveying many different messages about the one healed, the significance of the healing and the understanding of the world and of personal relationships within which it has taken place.

This is the background against which I find myself fearing that much of the current revival of, and enthusiasm for, the Christian ministry of healing in the signs and wonders sense, is liable to display superstition, promote sectarianism and promote spiritual self-indulgence. The promotion of offers of healing at particular times and places in relation to particular ceremonies or persons does seem very difficult to distinguish from the whole history of holy places, processes and people who are known throughout history and across the globe as the foci of superstitious hopes of miraculous healing from arbitrary divinities. Places, processes and people who gain a reputation for being successful and fashionable because of their healing episodes do become centres of sectarian and turned-inward devotion for those attracted by them. At the same time these successes are often, it seems to me, received self-indulgently both by those who bask in the glory of focusing and enabling them, and by those who count themselves privileged to be the subjects of such divine favour. The whole atmosphere and ambience are much more consistent with those aspects of primitive and superstitious belief which go with hope of, and submission to, divine arbitrariness and favours from a variety of deities, than with some enlarging entering in to a living faith in the God and Father of our Lord Jesus Christ and His universal and all-embracing Kingdom.

The Gospel message is not therefore being conveyed. It is, moreover, being seriously obscured - especially for all those in all the cultures and countries of the world who have been educated into those scientific, technological and critically sophisticated ways of thinking whereby they are liable to hold all religious ways of thinking to be superstitious. For so many people now religious ways are outmoded ways of responding to the problems, puzzles and mysteries of our human life, knowledge and activity in the world. Unreflective and over enthusiastic presentation of signs and wonders in the name of God, Jesus and the Gospel, is surely one more contribution to the evidence that religions are outmoded survivals in the world of today, pursued by deluded enthusiasts for their own escapist comfort.

So the really central biblical, theological and discipleship point that I have to make lies with the matter and the message of the Kingdom of God. We are Christians because we believe that God raised Jesus from the dead. This is the Jesus who proclaimed the coming of God's Kingdom and made it clear by word, action and life that He was wholly committed to the service and obedience of the Kingdom, even to death. He also taught his disciples to pray to God as Father and for the coming of the Kingdom. For this coming of the

Kingdom, in this praying to the Father, and because of His faith and obedience to God His Father, Jesus died. His faith was total, His commitment complete and His obedience ultimate. The result was death. But we know that this was not the last word about Jesus because the Spirit of the risen Jesus, who is the Holy Spirit of God the Father, has brought us into the company of those who know that Jesus is risen. We know therefore that Jesus was wholly right in His faith, His proclamation and His obedience. God is and He is indeed „our Father", who builds His Kingdom of love, justice and peace. The powers of the Kingdom are available now in the midst of our unfinished and troubled world, and the promise of the Kingdom will be fulfilled in the End. This is the Gospel, the Good News of God through our Lord Jesus Christ, in the power of the Spirit. This is the message which is witnessed to and proclaimed in the Gospels and the rest of the New Testament. This therefore is the message which is our calling to live by, to put into practice and to share. What might that mean for us in the Christian Medical Commission, where our concern is with Christian witness and service within the field of sickness, medical activities, health care and health care institutions?

As a preliminary answer to that question I would suggest, in the light of the arguments I have been putting forward, that we need to stop asking: „what is the Christian healing ministry today?". We need to change our introductory question into something like: „what are the contributions which Christians today are called to make in the fields of sickness, medical practice and health care delivery and institutions - and what are the ministries and activities which will promote these contributions?"

The reason for the change in the form of the question is to attempt to shift our concerns for Christian ministry in the health, medical and health care arena, in the direction of being a set of responses to the all-embracing and universal nature of God's Kingdom as that Kingdom is portrayed or implied in the New Testament. This requires shifting away from a central model of healing ministry which is too individualistic and focuses on particular episodes of healing or alleged healing which can easily be received as superstitious, sectarian and selfish. Similar healing episodes can also be peddled or offered by types of healing ministries which are pursued by persons and groups who have no idea of, and no concern for, the Kingdom of God as served by, and centred in, our Lord Jesus Christ. Jesus is the Word and Son of the one and only God, whose creation, care and Kingdom are to do with the whole earth from the beginning of creation and history to its end. So the Kingdom is to do with all peoples in general and every person in particular.

I said earlier that an episode of healing as such may be experienced in a variety of ways and understood both by the subject and by participants and observers as conveying many different messages about the one healed, the significance of the healing, the understanding of the world and of personal relationships within which it has taken place. The aim of any Christian ministry must be to promote an understanding of the world which finds it to be open to the possibilities and promises of the Kingdom of God. Personal relationships therefore are to be received and developed as possibilities for growing in, and promoting the growth of, the love, peace and justice of this Kingdom. Receiving a Christian ministry and perceiving a Christian message in the field of sickness, healing and health care is not therefore, so to speak, to receive a religious dose or injection, along with other doses and injections, which contribute to the improvement in one's felt well-being. Nor is it to be co-opted into a religious group or practise because someone or something associated with such a group or practise has „done you good". To receive or respond to a Christian sign or message about the Kingdom is to be opened up; to be drawn into, and to receive, both a place to rest in and a part to play in, the whole drama, direction and promise of God in His universal purposes of creation and fulfilment. This, of course, embraces being saved from what is destructive, distorts and is divisive, and being saved for the community of celebration and sharing which is both the gift and the completion of the Kingdom.

We are not called to make people religious but to invite, co-opt and coordinate them into the communication, sharing and celebrating of their best selves, which is the calling and purpose of God in His Kingdom of holiness, justice and peace. It is very necessary to recover this vision of the way the Kingdom of God is concerned with both universality and particularity, with the fulfilment of everything in creation in relation to the salvation, restoration, and completion of personal and particular human beings. For human life everywhere is threatened with diminishment, disillusion, despair and destruction. High hopes of politics, economics, development, science, technology and medicine are just not being fulfilled. They are all producing as many, if not more, threats than promises. The CMC knows a lot about this in the medical and

health spheres. It has experiences of hopelessly overtechnologised and expensive hospitals. It knows about medical and professional bureaucracies and rigidities. It has studied the manipulation, exploitation and abuses of the pharmaceutcal industry. It is regularly concerned with the illnesses and shortages produced by the use of pesticides, environmental degradation, and the effects of industrial pollution and waste. People are too often not cared for, while power and profit are. Meanwhile people across the world seem engulfed in acceptance of all this, or indifference to it, and there is very little hope or vision of better things.

What signs of the Kingdom, and what messages of the judgement, salvation and love of God, can be set up under these circumstances by Christian ministries in the area of medicine, healing and health care today? The signs, I would suggest, must have to do with having a hopeful care for persons - in both the deepest possible sense of individual personal identity, and in the widest possible scope of personal responsibility and community. This individually penetrating and socially ever-expanding hope and care, is in the name of God the Father through Jesus Christ in the power of the Spirit. That is to say it is hope and care informed, corrected, directed and extended by commitment to the Kingdom of God.

Because of what we know as Christians about the God of love, incarnation and the Spirit, and therefore about the possibilities and promises of His Kingdom, we know that a person is never simply „a case". Every human being is a person in the image of God with the potential of being both a contributing and a celebrating member of the Kingdom of God. This is basically true and challenging whatever the urgency of the case of invasion by disease, distortion or accident, or the misery of unease, which a person as a patient presents to a medical person or a health care institution. The urgency of the case has, of course, to be dealt with by whatever means are immediately available. But the really basic concern is what will the person make of what is happening to him or her, and what will the suffering and experiences do to him or her?

At least this is the really basic concern for those of Christian faith and calling. For we know that the fundamental good news about men and women as human beings and persons is that the Kingdom of God is open to us. Therefore suffering and healing, enduring, and surviving, being restored to health or facing death, are all matters of the greatest depth and promise. They are not simply routine matters in the serial progression of a human animal from birth to death. Of course, there are other religions and philosophical understandings of human beings than the Christian one which locate human living in broader and deeper contexts than that of highly developed animals, but I am outlining a Christian approach. I have no time and space to pursue here the very important matter of Christian collaboration with men and women of other faiths and other very deep perspectives on human living in the medical and health care fields. I am confining myself here to what I hope is a suggestive and useful outline of the Christian contribution in this field. If we would serve with all men and women of good will and deep concern in the arena of sickness, healing and health care, we owe it to men and women at large to be as clear as possible about the distinctive hope, understanding and faith, to which we are called to contribute. What would God have us in particular to offer to men and women in the sufferings and possibilities of their lives?

When men and women fall ill they are called in question - what life possibilities are open to us? Who are we? What prospects have we got? How then do we Christians enable signs and messages to be picked up during the delivery of health care so that people can realise that although they are called in question there is an affirming, hopeful and promising answer to be heard - the answer of the love and Kingdom of God? This is an answer, moreover, which is not a theory but a presence, and not wishful thinking but a living and shared hope.

All this requires, I believe, that Christians with a strong sense of calling, commitment and mission, should be involved in the field of health, medicine, healing and health care, in three interconnected ways, or at three interrelating levels. These are the levels and ways of service, of sacrament and of challenge.

The basic level is the way of service. This is the service which we long to share and offer (and, of course, to receive) because such service is at the heart of what it is to belong to one another as children of God, as brothers and sisters, cousins and friends, in the potential family of all human beings in the Kingdom of God, and fellow citizens of our various families, nations and groupings on our way to the community and the celebration of the City of God. It is a lovely and a loving thing to serve one another and to receive the service of one another - because we are loved, because we are made for love, because we long for love and

because we are to be fulfilled by love. We are called to offer ministries which kindle in ourselves and all those around us a renewed understanding of belonging, and calling and caring.

Service is not to be given because it is a duty, although duty comes into it. It is not to be offered because it is a responsibility, although responsibility comes into it. (However we need to beware of feeling so responsible FOR people that we have such a duty TO them that we have the need and the right to dominate them and force upon them our ways of being healthy and being themselves). Service is not to be given because it fulfils US (although our only ultimate fulfilment lies in the service given and received in the Kingdom of God with total equality, complete freedom, and liberating joy). Service is to be offered because it is at the heart of the praise and the glory of God. For God is Love and His Son was among us as one who served - who was enslaved by His service and done to death so that love may find a free, although costly, way through all that oppresses, contradicts and diminishes it. So, service is an act of praise, a reflection of glory and a longing to be changed so that we may all become one in the community, service and celebration of the Kingdom of God. This is the Kingdom also of our perfected and perfecting love, reflecting, engaging - and in some mysterious way enhancing - the perfect and always persevering love of God.

This means that we need to set up ways of infiltrating medical services, professional activities and the operations of institutions of health care. We have to develop a renewal of an informed sense of calling, service and hope which sees medical treatment, health care services and hospitals, with all other health care institutions, as opportunities for serving people according to their needs and their possibilities. These are possibilities which are informed by the praise and glory of love, which is the praise and glory of God. But this approach must be learnt and monitored, developed and tested. For it is not a matter of romanticism and sentimentality. It is a matter of rigorous realism informed by developing discipleship, deep reflection, and the lively worship of God.

Medical treatment and health care, however much it must be professionally particularised and targeted for whatever cases are presented in the persons who need and seek treatment is, or ought to be, part of an offering and sharing in the possibilities of the love of God, for the sake of the whole person, in relation to the open possibilities of the Kingdom.

This may sound like rhetoric but it is an invitation and an opportunity to recapture the exercise of medicine and the provision of health care for broad, deep and far reaching humanitarian reasons and purposes. Sickness and ill health call people in question. The Christian contribution to healing and health, the ministry which we ought to provide, with any others of good will who will join us, is the ministry of respect, care, hope and promise for the whole person in relation to the prospects for the whole of the local society, and indeed for the whole world. This means criticism of any exercise of medical technologies or pharmaceutical manipulations that processes a patient with a routine treatment which is not in consideration of that person as such. It means a concern to provide, as part of medical treatment as well as along side it, a pastoral care and concern focused on the deep and longing needs and aspirations of each and every patient. It means also a realistic readiness to recognise and accept the limits of treatment, both the limits of its availability and the limits of its possible effects, so that there is a message to people that it is not true that because the possibilities or availabilities of medicine are exhausted, therefore the possibilities of life, future and hope are exhausted. This calling to service in the name, power and promise of the Kingdom is a difficult and urgent calling. People have forgotten - or lack the resources to acknowledge - that patients are more than cases, that salvation is more than curing, and that death can be overcome by life.

So we must serve to restore hope, to deepen care for persons and to give signs that life, love and relationships go deeper than suffering and further than death. Saving the profession of medicine, the operations of health care institutions, and the attitudes, expectations and motivations of all working in these fields for the deep and hopeful service of persons is vitally important and an urgently needed Christian ministry and contribution. It is a contribution which needs to be very carefully directed to working with all other caring people who are concerned that medicine should give of its best, and that people who are called in question by sickness should receive comforting, hopeful and realistic reaffirmation and, where possible, restoration.

This way of service links up with, and is a part of, another dimension of Christian ministry in healing and health care which I want to call the dimension of ***sacrament***. I am using the word „sacrament" in a broad sense which extends out from the church use of the term to refer to the New Testament and evangelical use, with reference to the sacraments of Baptism and Eucharist or Lord's Supper. In these formal church sacraments material and ordinary things - water in Baptism and bread and wine in Eucharist - are used to perform acts in the context of a story and a ritual. These acts reenact what is believed to be the basic and all embracing acts and purposes of God. Through the sacrament of Baptism God's universal purpose and promise of washing away the effects of sin, and enabling a start on a new life, are presented and represented to, and for, the particular persons baptised. Likewise in the sacrament of the Eurcharist , God's universal gift of Himself in the life, death and Resurrection of Jesus is represented and made available concretely through the bread and wine and in the particular here and now of a particular celebration for the particular people who are present and who partake. This is to enable and strengthen us for particular life and service in the particular and concrete circumstances of our lives.

A sacrament acts to link up the universal purposes and offers of God to human and personal particularity through concrete means and acts in the context of an interpretative story or account. Christian ministries in healing and health care must precisely be concerned with taking hold of the ordinary stuff and circumstances of sickness, seeking for healing and providing care, and placing them both within the particular experience and needs of the patients, and within the story and promise of God's presence, purpose and possibilities of changing life and fulfilling life in the life and love of the Kingdom.

So we need to find ways of working in the field of medical practice and health care which concretely and specifically engage with people in their needs and fears, threats and longings, and locate what is going on and what is being done, offered and attempted, within the story and the possibility of God's presence, Kingdom and future. How do clinical encounters, diagnoses and interventions „speak" (verbally or non-verbally) to patients of care, hope and personal worth? How do we train and sensitize practitioners in medicine, nursing and auxiliary work to the ways of doing this? What every patient and every practitioner really need, as human beings working together for common caring, is a convinced awareness that there is mutual acceptance of the worth of every person. This is the worth that „we" and „they" enjoy and are entitled to because it is the worth going deeply into, and arising powerfully out of, the love of God and the promise of the Kingdom.

The sacramental way is to engage with both patients and practitioners right where they are in all their needs, all their medical, prosthetic and pharmaceutical activities, and all the personal problems of suffering and coming to terms with themselves, both as patients and as practitioners. This sacramental engagement is simply because that is the way that people in need and people seeking to give help should interact with one another. But the sacramental engagement has the additional all embracing dimension of seeking to convey the message, the presence and the promise of God and His Kingdom. So there is hope no matter what. Forgiveness is available for past troubles, confusions and sins. Presence is available in the midst of suffering, lostness and dying. Promise is there because God, as He is in Jesus, is powerful in the Spirit, to see people through their wildernesses and fears, to renew life and hope and relationships now, and to offer Resurrection when the earthly end comes.

This sacramental way is also a critical way. For, in practice and in aim the sacramental way is always challenging both practitioners and patients to realise the limits of what they are doing, what they are offering and suffering and what they can hope for, so that they and we may receive the newness and the enlargement of the wider life, love and hopes of the Kingdom. That is why Christian ministries in health care must be concerned with service, sacrament and challenge. God calls us to receive and enjoy His Kingdom. This call involves judgement for there are so many things which we take for granted, that we suffer from, and that we do, which are contrary to the Kingdom of love, peace, holiness and justice.

Disease and unease are, of course, one of the contradictions of the Kingdom. Some disease and unease arise out of the sheer mystery and absurdity of evil. Natural viruses torture and kill natural men and women. Much of disease and unease is the result of unhealthy and exploitative ways of human life in society. The very ways of responding to disease and unease are limited, distorted and monopolised by people of wealth, power and status, so that what could be done for the sick of the world is not done. And health care systems and institutions are quite as much the arena of personal and professional jealousies, exploitations and the

search for status as are all other human institutions - including the church. So Christian ministries which seek to set up signs of the Kingdom and to invite people into sharing the powers, hopes and promise of the Kingdom must be ministries of challenge. This is why we do well in the CMC to be concerned with all the social, political and professional dimensions of medicine and health care. It is not only episodes of sickness and disease which call persons in question. Millions of the poor, for example, are not so much called in question as ignored and insulted by concentration on ever more technologised and expensive medicine, located in great buildings and institutions, and maintained by prestige and high rewards - all of which put the cost of health care beyond not only the empty purses of the poor but beyond the budgets of many governments who have responsibility for so many of the poor. It also distorts the possibilities of making health care available widely in ways which would be of the maximum use for so many ordinary people whose sicknesses and weaknesses are not spectacular but endemic. The CMC has much experience of analysing and facing up to these communal, social and political aspects of the provision of health care and the practice of medicine. Facing up to the distortions, threats and shortcomings in this broad area is very much part of setting up Christian ministries in the field of medicine and health care. Encouraging a search for justice, setting up effective signs of communities which care, and encouraging such communities to join together in restoring societies which care, are all very much part of setting up signs of the Kingdom and of preparing the ground for the effective proclamation of the Gospel which says - God cares for all of us, God calls all of us to turn away from all that insults and distorts us towards the collaboration and caring of His Kingdom.

I would argue therefore that if we are to serve the Kingdom today and gain a hearing for the Gospel today in the field of sickness, healing, medical work and health care institutions, then we must be concerned with planning and working for signs of the Kingdom in the ways and dimensions of service, sacrament and challenge. These signs will not immediately and simply be recognisable to many as our attempts at translating the signs of the Kingdom recorded in the New Testament through episodes of miraculous healing associated with Jesus and the Apostles. The contexts in which we are called to gain a hearing for the reality of God, the Gospel of Jesus and the promise and glory of the Kingdom, are immensely different from the New Testament context. But we have the same faith, hope and love and the same Kingdom to receive from, contribute to and hope for. Also, men and women suffer in the same ways and long in the same ways to be brought out of being put to the question by sickness and death and opened up to hope and life and love. Therefore we have to persevere in discovering, developing and practising Christian ministries in the field of health and healing today which, by God's Grace, can today speak of the Kingdom of God in its universal scope, inexhaustible hope and the promise of the fulfilment of love.

Group Reports and Topics for the Future

1. Devotion
by Jaap Breetvelt

In DIFÄM's guest book I found, amongst the names of the participants of the 1964 Tübingen meeting, the name of one of my predecessors, Dr. Fre van der Horst. In one of his letters from that period, he describes how he experienced the Tübingen meeting:

One way or the other, I was invited to this meeting; I sneaked in, as it were, through the back door and found myself in the company of theologians who were speaking wonderful words and discussing ingriguing concepts, it was a fascinating discourse; myself not being a theologian, I missed the deeper meaning of most of what they said, but I recognized that it was meaningful and very special; let me try to summarize in my own words: local churches and congregations should be responsible for their own health and healing, and rural health work should be the foundation of all health services.

To be honest, I have to tell you that I have already found similar phrases about the role of the church in health care in Dr. van der Horst's earlier letters and policy documents dating from 1961/62. Tübingen confirmed and sanctioned what had been the thinking of several people, people that had until then been seen as odd, strange, even dangerous and threatening to the existing patterns of missionary practice.

In this 1995 meeting we have been listening to stories from the history of 25 years of CMC. We have in our midst some people who were present at that time and enjoy telling us how the CMC came about, and what inspired people to go into new directions, to break with the past.

Story telling is about the past; it is an interpretation of historical events, personal experiences, quite often crisis situations; it is talking after thinking, reflections on real experiences of real people in a real world.

Read: Psalm 85: 4-13 (translation the New English Bible)

In this psalm we hear, as a cry: Lord, you have turned away from us (we can as well say we have turned away from you), but give us new life, that your love will deliver us from despair, loneliness, suffering, the brokenness of human existence.

We stand in a long tradition of telling each other stories, interpretations of past experiences; the Old Testament is full of them; the disciples of Jesus Christ wrote their 'good news' stories about the real man Jesus they had met in their lives.

We want to tell each other, from generation to generation, from one continent to the other, from one section of society to the other, men and women, that what we see around us - the violence, discrimination, poverty, dehumanization, brokenness - is not meant to be. It is not as the Lord, who created the world and saw that it was good, has meant our society to be. And we tell each other in our stories, stories of our human lives, that Yahweh - 'I am who I am' - will be there when He is needed, will do what He has promised: peace to his people, deliverance is near, love and fidelity have come together, justice and peace join hands (Ps. 85: 8-10).

To tell our stories, we need an audience; as CMC needs a constituency, CONTACT needs readers, we need to meet with people to be able to, quite often stammering, say: I believe that what we see around us, is not the way God has meant the world to be.
I have a problem here. In my country, the Netherlands, it is increasingly difficult to have our youth listen to the stories, stories that seem to have lost their relevance to the younger generations in affluent societies. It looks like the chain of story telling and story tellers is being broken; we see a youth that has become alienated from their past, in a sense a generation of new illiterates.

Yesterday, we rightly concluded that CMC had paid little attention to the Northern countries and that the time had arrived to redress this omission: the North belongs to CMC's constituency in the same way as all other parts of the world, it might or should even be regarded as the new mission fields.

In this very special CMC consultation we have been listening to stories about change, new visions and new directions, words of encouragement and hope, but also to questions and doubts, stories about failures and shortcomings.

But in all we said was this underlying belief, in expressions of faith and repentance: Yahweh, our Lord is a loving God, a forgiving God, who will do what He has promised to do, and we may share in the vision that 'justice will go in front of each of us, and the path before our feet will be peace'.

2. Group Reports

Group I

Jack Bryant reported from his group by means of diagrams. Beginning with what CMC had done in the past:

- CMC assisted the churches' search for the Christian understanding of health and healing;
- promoted innovative approaches to health care,
- encouraged church-related programmes to collaborate with each other.

CMC contributed to a wider perspective of health but this did not trickle down to people in the churches, church structures, health professionals, or Christian social action groups.
In the midst of brokenness, injustice, dehumanisation and fragmentation existing in the world, CMC attempted through a ministry of healing, community participation and empowerment to create a situation where health, justice, dignity and identity could be found. This involved grass roots social activists and local congregations as well as health professionals.

Some current challenges were indicated as follows:

- no global solutions: begin with local analysis, capacity building,
- Bio-ethics,
- community-based caring capacity for the handicapped, elderly, orphans, people with HIV/AIDS, marginalised/poor, those discriminated against, human rights violations,
- strengthening PHC in context of community development,
- increase awareness of the elements of Christian understanding of health and healing.

Two ***constituencies*** were identified: the first included Christian coordinating agencies, church-based health services, pastors, local congregations, health professionals, Christian social activist groups, church establishments; the second group included international organisations, secular professional agencies, government agencies / policies.

Obstacles were noted, such as the risks and benefits of globalisation, unbalanced medicalisation, discrimination as a result of privatisation; growing scarcity of resources; intolerance, dependencies, rising conservatism.

For the Future: In relation to people in need, the following must be taken into account: local criteria, capacity for analysis, flexibility of response;

- migrants, women, the marginalised, broken families, the elderly, etc.
- violence,
- AIDS,
- promote greater understanding of health ministry for church constituency,
- church-related health care programmes: facilitate cooperation, share resources, encourage exchange of information and experiences, explore development of more effective programmes,
- promote a broad understanding of CMC, cf mandate of CMC (Evian Unit II Commission).

Group II

Jaap Breetveldt reported that his group had asked: When things happen, why and how? This might be a way of describing the strong and weak points of the whole 25 years of CMC. In response to the question: What was important? One was the study done by Jim McGilvray which initiated a number of things. Contact is an important way to share experiences and provide people with viable alternatives. History indicates that the justice issue came later.

- ***Constituency***: mainly the churches, congregations; but these should be more global in coverage, including the North and the West. Women's groups should be a focus; social movements, action groups, coordinating agencies, etc.

- ***Methodology***: How are we going to work in the future? Contact is still a very important means of communication. The way we work should be based on participatory action; should focus on women's groups in the churches. Coordinating agencies have a historical basis, but we should look for new allies - and redefine the meaning of coordinating agencies!

Some emphasis should be placed in the next four years on the question of what CMC sees as its role and vision, with regard to the Decade of the churches in Solidarity with Women.

Group III

Christoph Benn said his group had first discussed the achievements of the past: CMC had responded to the needs of the churches, and some good networking had taken place. CMC's influence depended on whether the time was ripe to receive its ideas in a particular area or not.

A ***challenge*** for CMC is to judge where the time is ripe and for what, and to be able to react to that, e.g. for talking to the churches on questions related to sexual ethics, HIV/AIDS, etc. This has to be addressed.

It is important to ask questions such as: Is the structure good enough to react to the challenges which are likely to come up, e.g. re garding the population issue? All CMC staff members have their own network of people all over the world with whom they work, dealing with different issues including AIDS, pharmaceuticals, capacity building, coordinating agencies. Are there some links between the programmes?
A weakness was seen in the fragmentation of the programmes and networks. This might result in missing a common vision. The workload of the staff does not allow them to take on the long lists of things to be dealt with. It was recommended to find a structure which allows the constant reflection of the common vision and the quick reaction to the most pressing needs which arise in health and healing in our world today.

Group IV

Rainward Bastian reported on an exciting discussion which had been based on the parable of the Sower. Responding to the question: What is our seed? The response was that people matter; so PHC must be an attitude, not a blueprint for a programme. CMC had reached out widely, in spite of its limited resources. The process involved finding out whether different groups were willing to take the seed - and many did take it and followed CMC's lead. But CMC has to remain close to the churches, and there was some rocky ground there. Then, how to deal with the stones? We cannot pull out the weeds without affecting the seeds. One crucial factor emerged: there is also an element of dying in the parable: sometimes the sowing instrument might die. You can only show that people matter if you are willing to die. Where has CMC to die?

The coordinating agencies can sometimes become weeds or stones. The effort to multiply the blueprints was almost killing CMC. One mistake was that we pushed to the ultimate the concept that "health is an end in itself". Good seeds may turn into weeds, while a weed may with care turn into a seed. Our system sometimes caused brokenness: we have to listen to people. We say "people matter"; do we also say "the churches matter, hospitals matter"? Of course hospitals are an area of concern but they should not overdo their demands on CMC. We should be content to erect signs. "We should sow and not be concerned with the growth or the harvest of the seed we sow".

3. Topics for the Future

Jaap Breetvelt led the devotion on Monday morning 23 January, prior to the final session, moderated by **Ana Langerak**, who invited all to share the insights and convictions the y had gained during the course of this consultation. The points that came out most clearly included the following:

- ***Globalisation***: CMC emerged from the missionary movement originating in the West focusing on activities in the South; now we have to extend that more widely to the West, to Central and Eastern Europe, to North America; CMC has to be aware of the social problems in all parts of our "One

World"; there is a fourth world in the industrialized countries and a first world in the less affluent countries

- An important agenda for the future will be ***Central and Eastern Europe*** as well as ***Central Asia***
- Taking seriously the ***ecumenical*** view in CMC's work; ***Orthodox*** and ***Roman Catholic*** participation must be ensured
- ***Networking***, linking with living networks of people who can help to share in the tasks of CMC which cannot all be done by the staff; there is no healing without togetherness; we must share experiences - participatory ecumenical approach; partnerships between institutions;
- ***Participation***: has to be differently expressed and worked out in different contexts
- Participation has to be expressed in the Methodology: P***articipatory Action Research (PAR); Community Based Action for Transformation (CBAT)***
- PAR which was applied to ***HIV/AIDS*** might be applied to other problems such as ***population***
- CMC should be an ***enabler***, work at consciousness raising, thus using its resources to greater advantage than for programmes, since resources are limited;
- The approach of CMC should be ***concept-oriented*** rather than programme-oriented
- ***Power***: analysing its implications on health; cf violence, unequal power relations in institutions; relation of power to health; reciprocity between rich and poor in a community;
- ***A bottom-up strategy has to be applied***
- Rediscover ***education*** in health
- Rethinking the meaning of ***"healing communities"*** ; How can this concept be communicated in the industrialized countries?
- ***Constituency***: how does it relate to the ecumenical communion taking into consideration unwanted political connotations. What does it mean for CMC to be part of the one ecumenical movement? How does it enlighten what goes on in other parts of the ecumenical movement
- To enhance the relevance of CMC's work to the ***medical profession***, not only to the institutions as such;
- How to reach ***medical schools*** and ***theological seminaries*** through CMC?
- How do we reach into the ***church*** with our ministry and become relevant in churches and congregations?
- ***Ethics***: specifying e.g. ethical considerations on a community level, (but select an aspect not being done by others); case studies, language of caring needed in the North for teaching ethics; CMC should look at different ethical issues;
- An important ethical concern is the need for a ***rationing of resources*** in all health care systems
- Greater attention should be paid to the question of ***pollution*** and health
- An important question is: How ***to help carers*** who accompany people suffering from a disease which has no cure? Accepting that life does have an end; stop prolonging life for the sake of prolonging it;
- CMC should accept its ***limits***: it should act and leave others to react; there is a limit to resources as well as to time, skills, people;
- Give more attention to ***listening*** than to doing;
- ***Creative tensions*** through shared vulnerability;
- The question of ***dependency and sustainability has to be addressed. We must*** look for local resources first;
- ***Self-reliance***: important for communities and for individuals; important tool for empowerment;
- ***Promotion of PHC***. There is still a need to promote this concept. But the question is: Should CMC do this on the same lines of what WHO is doing or should CMC do it in a different manner?

Programme for the Consultation

'25 YEARS OF CMC - THE VISION AND THE FUTURE'

DIFÄM Tübingen, 20. - 23. January 1995

Friday, 20.01.1995

Morning: Arrival
12.30 Lunch
14.00 Devotion

14.30 Ana Langerak, Rainward Bastian:
Welcome and Introduction to the Consultation

15.00 **First session**
Moderator: Philipp Potter
Speakers:
Sylvia Talbot: Reflections and Commemoration of the history of CMC
John Bryant: Reflections and Commemoration of the history of CMC
Ana Langerak: Current Issues and Future Challenges for CMC Churches' Action for Health in Unit II of WCC (Possibly together with other staff members of Unit II)

19.00 Buffet
(together with members of staff of DIFÄM, followed by informal discussions)

Saturday, 21.01.1995

8.00 Morning devotion
8.30 Breakfast

9.30 **Second session**
Moderator: Rainward Bastian
Speakers:
John Bryant: 'Health and Justice Today'
Sylvia Talbot: 'Women and Health'
Hari John: 'Health, Healing and Community Development'

12.30 Lunch

14.30 **Third session:**
Moderator: Linda Senturias
Speakers:
Haakan Hellberg: 'The CMC and its Impact on Secular Organisations'
Mabelle Arole: 'The Impact of CMC on Community Health'
Mabel de Filippini: 'The Impact of CMC in Latin America'
Christoph Benn: 'The Impact of CMC on Health Care in Industrialized Countries'

19.30 Swabian Dinner

Sunday, 22.01.1995

8.00 Morning devotion
8.30 Breakfast

9.30 **Fourth session:**
Moderator: Daleep Mukarji
Presentation by 'Listeners'
Speakers:
Oliver Duku: 'Primary Health Care: The Vision of the Churches on Health Care'
David Jenkins: 'The Christian Healing Ministry Today'

12.00 Lunch

14.30 **Fifth session:**
Moderator: Ana Langerak
Working Groups on 'Developing a Vision for the Future'
Plenary session

18.00 Dinner
20.00 Worship Service

Monday, 23.01.1995

8.00 Morning devotion
8.30 Breakfast

9.30 Evaluation of the Consultation

11.00 Planing for a publication

12.30 Lunch
closing of the Consultation

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